COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2014-024

In the Matter of	)
WILLIAM J. MUGG, 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 William J. Mugg, 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. 12-223.

Biographical Information

1. The Respondent was born on March 29, 1945. He graduated from the University of Michigan Medical School in 1970. He is certified by the American Board of Internal Medicine. He has been licensed to practice medicine in Massachusetts under certificate number 38722 since 1975.

2. The Respondent has a solo private practice in South Hadley, Massachusetts.

Factual Allegations

Patient A

3. Patient A was born in 1953.

4. Patient A had a medical history which consisted of spastic cerebral palsy, seizure disorder, gastroesophageal reflux disease (GERD), GI bleed, severe anemia, esophagitis, extremity contractures, and multiple G-tube placements.

5. Patient A was non-communicative and had a limited ability in his earlier years to ambulate.

6. In July 2000, Patient A's sister became Patient A's legal guardian.

7. Patient A lived with his sister, who was his primary caregiver following the death of Patient A's mother in 2009.

8. The Respondent became Patient A's primary care physician in approximately 1985.

9. By 1999, Patient A was cachectic and contracted.

10. Patient A relied on external sources for feeding and nutrition.

11. In approximately 2000, the Respondent began making annual house calls to examine Patient A because Patient A's sister was unable or unwilling to bring Patient A in to the Respondent's office.

12. The average length of the Respondent's house call to Patient A was about 20 minutes.

13. The Respondent's examinations consisted of checking Patient A's blood pressure, heart, lungs and G-tube site, during the times he had one in place.

14. The Respondent did not perform a total body check on Patient A during the examinations because having to move or reposition Patient A with his contracted extremities would have caused him pain.

15. The Respondent did not check Patient A's weight or dentition during the examinations.

16. Patient A's sister decided not to have Patient A receive dental care because Patient A would have needed to be placed under general anesthesia due to his spasticity.

17. At each visit to Patient A's house, the Respondent would tell Patient A's sister to make an appointment to have Patient A seen by the Respondent in six months.

18. Patient A's sister never made a six month appointment.

19. In general, Patient A's sister would only call the Respondent's office when Patient A needed his medications refilled.

20. By 2001 and continuing until his death in April 2012, Patient A took Depakote, an anticonvulsant, for his seizure disorder.

21. Because of serious side effects associated with Depakote use, Patient A needed to have blood drawn to check his Depakote levels on a regular basis.

22. For several years, the Respondent was unable to find someone to go to Patient A's house to draw blood.

23. Patient A's sister did not take Patient A to a clinic to have his Depakote level checked.

24. From approximately October 2005 until May 2009, Patient A's blood was not tested.

25. From 2009 until 2012, Patient A's blood was tested approximately once a year.

26. The Respondent examined Patient A at his home on January 9, 2012.

27. The Respondent did not notify the Disabled Persons Protection Commission because he did not have any concerns regarding the care Patient A received at home.

28. At approximately 2:45 a.m. on April 19, 2012, Patient A was brought by ambulance to Holyoke Medical Center (Holyoke).

29. Patient A had bright, red blood per rectum.

30. Patient A was cachectic, malnourished and emaciated.

31. Patient A weighed 84 pounds and was 67 inches tall.

32. Patient A had ecchymosis around his left ear and neck areas.

33. He had broken teeth and dental ulcers with infections along his gum line.

34. He also had multiple stage IV decubitus ulcers.

35. Although the decubitus ulcers were down to the bone, they were relatively clean and without obvious infection.

36. Patient A had hypoxemia and a rapidly declining respiratory status.

37. Patient A was pronounced dead on April 20, 2012 at 3:02 p.m.

38. The Medical Examiner's Office determined that the manner of Patient A's death was natural and that the cause was complications of neurodegenerative/seizure disorder.

39. The Respondent's treatment of Patient A fell below the standard of appropriate medical care in that:

a) Given Patient A's medical complexities, including his seizure disorder, immobility and dependence, the Respondent should have examined Patient A on a quarterly basis, which he failed to do;

b) The Respondent failed to adequately monitor Patient A's laboratory status regarding nutrition, such as total protein, serum albumin, prealbumin, and vitamin levels on a regular basis;

c) The Respondent failed to adequately monitor Patient A's laboratory status regarding his anticonvulsant therapy;

d) The Respondent's documentation of Patient A's examination did not include the state of Patient A's dentition or oral hygiene, nor did the Respondent's documentation include any discussion of examining Patient A's skin, a mandatory part of the care of the chronically bedridden;

e) The Respondent's documentation for Patient A did not provide adequate information to assess the progress of Patient A's illness, including his nutritional status, and reactions to medications;

f) The Respondent had a responsibility to pursue the best interest of Patient A, even if this meant challenging the wishes of the legal guardian. The Respondent failed to report Patient A's condition to the Disabled Persons Protection Commission, as required by law.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, ninth 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, by practicing medicine with negligence on repeated occasions.

B. Pursuant to G.L. c. 112, §5, ninth par. (b) and 243 CMR 1.03(5)(a)2, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician committed an offense against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder. More specifically:

1. G.L. c. 19C, §10, which provides that a physician who has reasonable cause to believe that a disabled person is suffering from a reportable condition, i.e. an act or omission which results in serious injury to a disabled person, "shall notify the commission orally of any reportable condition immediately upon becoming aware of such condition and shall report in writing within forty-eight hours after such oral report;" and,

2. 243 CMR 2.07(13)(a), which requires a physician to:

a. maintain a medical record for each patient, which is adequate to enable the licensee to provide proper diagnosis and treatment; and

b. maintain a patient's medical record in a manner which permits the former patient or a successor physician access to them.

C. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

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,

Kathleen Sullivan Meyer

Kathleen Sullivan Meyer, Esq.
Board Vice Chair

Date: June 25, 2014

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