COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2023-025

In the Matter of	)
WILLIAM A. MITCHELL, MD.	)

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 A. MITCHELL, 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 Nos. 18-399 and 20-185.

Biographical Information

1. The Respondent graduated from the Columbia University College of Physicians & Surgeons in 1976. He is certified by the American Board of Orthopedic Surgery. He has been licensed to practice medicine in Massachusetts under certificate number 52543 since 1984. He has privileges at Newton-Wellesley Hospital.

Factual Allegations

Patient A

2. Patient A is a female who was 69 years-old in 2019.

3. On October 1, 2019, the Respondent evaluated Patient A who had complaints of right shoulder pain which was chronic for two years.

4. Patient A had a previous surgery on the same shoulder.

5. Patient A had significant co-morbidities including severe morbid obesity, asthma, and sleep apnea.

6. Patient A's morbid obesity, chronic asthma, and sleep apnea increased her risks of postoperative pulmonary complications.

7. On October 1, 2019, the Respondent reviewed with Patient A a recent shoulder MRI.

8. The MRI found partial tears of the rotator cuff and a dislocated but not a disrupted bicep tendon.

9. The Respondent recommended arthroscopic surgery based on clinical findings.

10. On November 8, 2019, Patient A underwent arthroscopic repair of her rotator cuff tear.

11. The fact that this second surgery was a revision surgery made the second surgery more complex.

12. Patient A's hospital course was complicated by an overnight stay because of shortness of breath following the surgery, which was attributed to her morbid obesity, asthma, and the nerve block.

13. The surgery was supported by clinical findings. MRIs do not always detect important issues.

14. The Respondent failed to:

    a. Document a period of nonoperative treatment or shared decision making with Patient A accepting the increased risks of the surgery.

    b. Document his surgical decision making in light of the MRI findings.

Patient B

15. Patient B is a female who was 57 years-old in 2017.

16. The Respondent treated Patient B on sperate occasions for left knee pain and for left shoulder pain.

17. On December 14, 2017, the Respondent evaluated Patient B who had complaints of left lateral knee pain.

18. The Respondent diagnosed Patient B with a lateral meniscus tear.

19. On December 19, 2017, an MRI documented a medial meniscal tear and mild osteoarthritis – it did not show a lateral meniscal tear.

20. Although, Patient B's knee symptoms and examination did not correlate to her MRI findings, the Respondent recommended surgery.

21. On January 5, 2018, the Respondent performed an arthroscopic surgery on Patient B's left knee.

22. There is no documentation in the operative note that the lateral meniscus was examined.

23. On November 6, 2018, the Respondent saw Patient B for left shoulder pain.

24. The Respondent diagnosed instability of the shoulder and recommended an MRI of the left shoulder.

25. The MRI showed tendinosis of the rotator cuff, tendinitis, and bursitis with evidence of a previous surgery. A partial rotator cuff tear was also seen.

26. There was no evidence of any structural injury that would cause instability.

27. On August 20, 2019, the Respondent re-evaluated Patient B, reviewed the MRI, and recommended surgery.

28. The Respondent's preoperative diagnosis and indications for surgery include a rotator cuff tear and instability.

29. On October 11, 2019, Patient B underwent left shoulder arthroscopic surgery.

30. Examination under anesthesia documented the shoulder was stable. A near full thickness rotator cuff tear was diagnosed at surgery and repaired.

31. In the operative note there is no documentation that the anatomic structures that contribute to shoulder instability were examined.

32. The Respondent failed:

a. To document nonoperative treatment options.

b. To document in the operative note that he correlated pre-operative diagnosis with surgical treatment.

c. To document that he correlated imaging findings with clinical findings prior to surgery.

Patient C

33. Patient C is a male who was 57 years-old in 2019.

34. On July 16, 2019, the Respondent evaluated Patient C who had complaints of chronic bilateral knee pain that had been symptomatic for more than five years.

35. The Respondent diagnosed Patient C with chondromalacia patella and a possible meniscal tear and referred him for an MRI of his right knee.

36. On July 18, 2019, a right knee MRI report documented a possible lateral meniscus tear and mild thinning of the cartilage consistent with mild osteoarthritis.

37. On July 25, 2019, the Respondent recommended Patient C undergo arthroscopic surgery.

38. The Respondent's preoperative diagnoses included instability and chondromalacia of the right knee.

39. On August 23, 2019, Patient C underwent arthroscopic surgery of the right knee.

40. The procedure was a right knee partial lateral meniscectomy, microfracture and drilling of the femoral condyle.

41. The Respondent failed:

a. To document discussions with Patient C regarding nonoperative treatment options.

b. To document why his preoperative diagnosis differed from his operative findings.

Restriction of Hospital Privileges

42. Patient D is a male who was 77 years-old in 2019.

43. On December 30, 2019, the Respondent performed a revision of a right total knee arthroplasty on Patient D.

44. The Respondent began the surgery and had Patient D placed under anesthesia without the implant being present in the operating room. The Respondent understood that the implant would be readily available. It was brought into the room in 20 minutes and the surgery proceeded successfully.

45. On February 13, 2020, the Respondent's surgical privileges at Newton-Wellesley Hospital were restricted.

Legal Basis for Proposed Relief

A. The Respondent has violated G.L. c. 112, § 5, eighth par. (b) and 243 CMR 1.03(5)(a)2 by committing an offense against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder—to wit 243 CMR

2.07(13)(a), which requires a physician to maintain a medical record for each patient, which is adequate to enable the licensee to provide proper diagnosis and treatment.

B. 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,

Holly Oh. M.D.

Date: July 13, 2023