OMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2014-024

In the Matter of	)
WILLIAM J. MUGG, M.D.	)

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, William J. Mugg, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 12-223.

Findings of Fact

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.

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.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, ninth par. (c) and 243 CMR 1.03(5)(a)3, in that he placed into question his competence to practice medicine by practicing with negligence on repeated occasions.

B. The Respondent has violated G.L. c. 112, § 5, ninth 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:

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. The Respondent has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982).

Sanction and Order

The Respondent's license is hereby indefinitely suspended. Any stay will be conditioned upon the Respondent's entry into a five-year Probation Agreement that includes:

a) Continuous Professional Development (CPD) requirements – over and above those required for licensure, including five (5) CPD credits in statutory reporting requirements for physicians and five (5) CPD credits in medial record-keeping within one year from the Respondent's entry into the Probation agreement;

b) A Practice Audit – by a Board-approved entity to be completed within ninety (90) days of the execution of the Probation agreement; and, an amendment of the Probation Agreement within sixty (60) days of the completion of the audit to incorporate the auditor's recommendations for remediation;

c) Monitoring – of the Respondent's practice, beginning on the date the Board approves the Probation Agreement, by a monitor who shall:

   i. engage in review of no fewer than ten (10) randomly-selected patient charts of patients cared for by the Respondent, monthly, for compliance with applicable standards for clinical care and record keeping; and,

   ii. submit monthly monitoring reports to the Board; and

d) Any other terms and conditions that the Board deems appropriate.

Execution of this Consent Order

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated for the duration of this suspension. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

William J. Mugg, M.D. — 3/20/14
William J. Mugg, M.D. — Date
Licensee

Diane Fernald — 3/25/14
Diane Fernald, Esq. — Date
Attorney for the Licensee

Pamela J. Meister — 3/31/14
Pamela J. Meister, Esq. — Date
Complaint Counsel

So ORDERED by the Board of Registration in Medicine this 25th day of June, 2014.

Kathleen Sullivan Meyer
Kathleen Sullivan Meyer, Esq.
Board Vice Chair

SENT CERTIFIED MAIL 6/26/14 mg