FILED

FEB 4 2016

Kevin Westray, Legal Assistant

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, **Petitioner,**	:	
	:	Docket No.: OSAH-CSBME-PHY-1620386-Malihi
v.	:	
DAVID WILLIAMS, M.D., **Respondent.**	:	Agency Reference No.: 20160020

INITIAL DECISION

I. Procedural History

Petitioner, the Georgia Composite Medical Board (hereinafter "the Board"), filed this matter for the purpose of pursuing disciplinary action against Respondent, Dr. David Williams, and his license to practice as a physician. A hearing was held on January 25, 2016. Petitioner was represented by Wylencia Monroe, Esq. Respondent failed to appear.[1] Based upon the testimony presented at the hearing, and having carefully considered the entirety of the evidentiary record in this matter, the Court hereby **GRANTS** the Board's request to impose sanctions against Respondent's license to practice as a physician.

II. Findings of Fact

1.

Respondent is licensed to practice medicine in the state of Georgia and was licensed as such at all times referenced in this Decision. Respondent's specialty is family practice. (Statement of Matters Asserted ¶ 1; Petitioner's Exhibit 1; Testimony of Robert Jeffery).

[1] Both an initial Notice of Hearing and a Corrected Notice of Hearing were sent by certified mail to Respondent's last known address of record with the Board, 2799 Delk Road, Suite 100, Marietta, GA 30067. The Corrected Notice of Hearing was delivered on November 18, 2015. Service was therefore proper, and the Court proceeded to hear the evidence against Respondent as if he had been present. *See* O.C.G.A. § 43-1-19(k).

2.

During or between the dates of December 9, 2010, and April 28, 2011, Respondent treated patient W.B., a woman in her mid-forties. (Petitioner's Exhibit 3).

3.

On or about December 20, 2010, W.B. presented to Respondent's office, complaining of swollen ankles, a bloated stomach, and "spitting up blood." At that visit, Respondent did not order or perform any tests, and he did not document any physical examination. Respondent diagnosed W.B. with congestive heart failure, as well as a recent viral upper respiratory infection and anemia. Respondent did not admit W.B. to the hospital at that time. Instead, as treatment, Respondent prescribed two medications, Lasix and digoxin. (Petitioner's Exhibit 3; Testimony of Dr. Mark McElHannon).

4.

On or about April 26, 2011, W.B. presented to Respondent's office, complaining of blurred vision and thirst. At that visit, Respondent performed a finger-stick blood glucose test, which measured W.B.'s glucose level at more than 500. No other tests were performed, and Respondent did not document any physical examination. Respondent diagnosed W.B. with diabetes and administered an insulin shot. Respondent also placed W.B. on two diabetic medications and prescribed the "BCG" vaccine. Respondent did not admit W.B. to the hospital on this occasion, and his clinic notes did not indicate when or whether W.B. should return for a follow-up visit. (Petitioner's Exhibits 3 & 4; Testimony of Dr. McElHannon).

5.

The Board initiated an investigation into Respondent's treatment of W.B. As part of the investigation, Respondent submitted a signed and notarized written statement to the Board on

July 20, 2011, detailing his treatment of W.B. In the statement, Respondent asserted that he first saw W.B. on December 9, 2010, when she was diagnosed with pneumonia. Also during this initial visit, W.B.'s "cardiac values were normal but her EKG [electrocardiogram] was borderline." Respondent further stated that, during W.B.'s visit on December 20, 2010, W.B. "was found to have edema but there was some improvement in her pneumonia." He did not mention any diagnosis of congestive heart failure. Respondent also contended that he believed prescribing digoxin and Lasix "was appropriate." As for W.B.'s visit on April 26, 2011, Respondent asserted that he administered a BCG vaccine, "but only for immunization purposes." (Petitioner's Exhibit 2; Testimony of James Stephen Wills).

6.

In October 2013, Mark Andrew McElHannon, M.D., conducted a peer review of Respondent's treatment of W.B. on behalf of the Board. Dr. McElHannon is a physician licensed to practice medicine in the state of Georgia and is board certified in family practice. He earned his medical degree from the Medical College of Georgia and has seventeen years of experience in family practice, in both an outpatient and hospital setting. He currently serves as the medical director of a hospitalist program in Rome, Georgia. (Testimony of Dr. McElHannon).

7.

After reviewing the documentation relevant to Respondent's treatment of W.B., Dr. McElHannon concluded that Respondent's care of W.B. departed from and failed to conform to the minimum standard of acceptable and prevailing medical practice. Specifically, Dr. McElHannon testified that, prior to diagnosing W.B. with new-onset congestive heart failure on December 20, 2010, Respondent should have attempted to rule out other diagnoses, such as a

pulmonary embolism or a heart attack. However, Respondent did not perform any tests on December 20 that could have ruled out such conditions, such as a chest x-ray, extensive blood testing, an electrocardiogram, or heart monitoring. Respondent also failed to document any type of physical examination, despite the severe symptoms that W.B. presented. Dr. McElHannon further testified that hospitalization would have been the most appropriate measure in W.B.'s case, so more extensive testing could be performed. As for Respondent's decision to prescribe digoxin, Dr. McElHannon concluded that such treatment fell below the minimum standard of care. A digoxin prescription for new-onset congestive heart failure is highly unusual, particularly when the patient has not undergone extensive evaluations and is not receiving the medication from a cardiologist. Dr. McElHannon also testified that Respondent's clinic notes for the December 20 visit were "pretty cryptic," difficult to read, and extremely brief given W.B.'s complicated condition. (Testimony of Dr. McElHannon).

8.

Dr. McElHannon also concluded that Respondent's treatment did not meet the minimum standard of care during W.B.'s visit on April 26, 2011. At a minimum, Respondent should have performed additional blood tests, kidney and liver tests, and Hemoglobin A1c testing for diabetes. Additionally, given W.B.'s high glucose level, Respondent either should have admitted W.B. to the hospital or scheduled a close follow-up visit within a week. Dr. McElHannon further stated that he found no medically justifiable reason for W.B. to receive the BCG vaccine, which is not a generally accepted treatment for diabetes. Instead, the BCG vaccine is used to immunize against tuberculosis in various parts of the world, and its only accepted use in the United States is for treating bladder cancer. Dr. McElHannon also testified that Respondent failed to thoroughly document the April 26 visit, as his clinic notes were difficult to read and

extremely brief regarding W.B.'s condition and treatment. (Testimony of Dr. McElHannon).

III. Conclusions of Law

1.

Because this matter concerns the Board's proposed imposition of sanctions on Respondent's license to practice medicine, the Board bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

Professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has engaged in unprofessional conduct that fails to conform to the minimal reasonable standards of acceptable and prevailing practice. O.C.G.A. § 43-1-19(a)(6).

3.

In turn, under O.C.G.A. § 43-34-8(a), the Board has the authority to discipline a physician upon a finding that the licensee has "[e]ngaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person." O.C.G.A. § 43-34-8(a)(7).

4.

Pursuant to the Board's Rules, unprofessional conduct includes the following:

> (14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.
>
> (15) Failing to use medications and other modalities based on generally accepted or approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction in the treatment of patients. However, nothing herein shall be interpreted to prohibit investigations conducted under protocols approved by a state medical institution permitted by [the Georgia Department of Human Services] and with

human subject review under the guidelines of the United States Department of Health and Human Services.

. . .

(18) Any other practice determined to be below the minimal standards of acceptable and prevailing medical practice.

Ga. Comp. R. & Regs. 360-3-.02.

5.

If the Board finds cause for discipline, it is authorized to "deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician . . . for all the grounds set forth in O.C.G.A. § 43-34-8." Ga. Comp. R. & Regs. 360-3-.01; *see also* O.C.G.A. § 43-34-8(b)(1). Any fine may not exceed $3,000.00 for each violation of a law, rule, or regulation. O.C.G.A. § 43-34-8(b)(1)(G).

6.

The Board proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct in violation of O.C.G.A. § 43-34-8 and Ga. Comp. R. & Regs. 360-3-.02. Such conduct departed from, or failed to conform to, the minimum standards of acceptable and prevailing medical practice.

7.

First, Respondent failed to perform thorough evaluations or necessary laboratory or radiographic studies when diagnosing W.B., in violation of Ga. Comp. R. & Regs. 360-3-.02(14). Respondent's initial diagnosis of new-onset congestive heart failure on December 20, 2010, should have prompted a more thorough physical examination and additional testing, such

as extensive blood testing and heart monitoring, to rule out other conditions.[2] During W.B.'s visit on April 26, 2011, Respondent failed to conduct the minimum tests necessary for W.B.'s elevated glucose level, such as kidney tests and Hemoglobin A1c testing for diabetes.

8.

Second, Respondent failed to use generally accepted medications and other modalities when treating W.B., in violation of Ga. Comp. R. & Regs. 360-3-.02(15). Despite Respondent's assertion to the contrary, his decision to prescribe digoxin on December 20, 2010, was not appropriate. Digoxin's use is highly unusual for new-onset congestive heart failure, particularly in a case like W.B.'s, where the patient has not yet undergone extensive testing and is not being treated by a cardiologist. Additionally, no medically justifiable reason existed for Respondent to administer the BCG vaccine after diagnosing W.B. with diabetes on April 26, 2011. Although Respondent claimed that the vaccine was "for immunization purposes," the vaccine is only used to immunize against tuberculosis in other countries, and its generally accepted use in the United States is for treating bladder cancer, not diabetes.

9.

Third, Respondent's treatment of W.B. fell below the minimal standards of acceptable and prevailing medical practice, in that he failed to thoroughly document W.B.'s conditions and treatments. *See* Ga. Comp. R. & Regs. 360-3-.02(18). As an initial matter, Respondent's clinic notes for December 20, 2010, and April 26, 2011, were difficult to read. The notes that were

[2] In his July 2011 letter to the Board, Respondent contended that he performed an electrocardiogram and a chest x-ray during W.B.'s initial visit eleven days earlier, on December 9, 2010. However, Respondent's clinic notes for December 9 do not indicate that he performed or reviewed an electrocardiogram. Also, while Respondent did make a notation regarding an x-ray in his December 9 notes, Dr. McElHannon testified that he did not find any documentation of the results of that x-ray in W.B.'s clinic notes. Moreover, regardless of the studies performed on December 9, there is no evidence that Respondent performed any testing at all—including an electrocardiogram or an x-ray—on December 20, 2010, the day he made the actual diagnosis of congestive heart failure. (Petitioner's Exhibits 2 & 3; Testimony of Dr. McElHannon).

legible were extremely brief and lacked sufficient detail about W.B.'s condition and treatment, which would be essential given the patient's severe symptoms and diagnoses.

10.

The General Assembly clearly intended to safeguard the public by requiring that physicians adhere to a minimum standard of care when treating patients. By (1) failing to conduct adequate examinations and testing; (2) prescribing inappropriate treatments; and (3) maintaining insufficient medical records, Respondent has engaged in unprofessional conduct that put his patient's health at risk. Hence, the Board is authorized to sanction Respondent's license. *See* O.C.G.A. § 43-34-8(a), (b)(1); Ga. Comp. R. & Regs. 360-3-.01. Because these three violations are limited to isolated visits by a single patient, the Court agrees with the Board that sanctions less severe than the suspension or revocation of Respondent's medical license are appropriate. *See* O.C.G.A. § 43-34-8(b)(1). Therefore, this Court concludes that a monetary fine for each of the three aforementioned violations will serve as appropriate deterrence against Respondent's unprofessional conduct, with the maximum fine being applied to reflect the gravity of Respondent's conduct in light of W.B.'s severe medical conditions.[3] *See* O.C.G.A. § 43-34-8(b)(1)(G).

IV. Decision

For the foregoing reasons, it is recommended that the Board discipline Respondent by imposing a fine in the amount of $9,000.00, pursuant to O.C.G.A. § 43-34-8(b)(1)(G). The $9,000.00 fine consists of the maximum $3,000.00 for each of the following violations:

[3] In addition to fines, the Board also requested that Respondent pay $265.00 as reimbursement for the peer review, and attend forty hours of continuing medical education (twenty hours on diabetic care and twenty hours on congestive heart failure), which would be in addition to his regular education requirements. *See* O.C.G.A. § 43-34-8(b)(1)(H), (J). However, the Court finds these requested sanctions too arbitrary, as Dr. McElHannon did not testify on the cost of his services, and the Board did not present any other evidence regarding the peer review's expense or how the Board decided on the specific number of education hours.

(1) failing to use such physical examination, laboratory, or radiographic studies to diagnose a medical problem, pursuant to Ga. Comp. R. & Regs. 36-3-.02(14); (2) failing to use medications and other modalities based on generally accepted or approved indications, pursuant to Ga. Comp. R. & Regs. 36-3-.02(15); and (3) engaging in unprofessional conduct by failing to maintain thorough medical records, pursuant to Ga. Comp. R. & Regs. 36-3-.02(18).

SO ORDERED this 4th day of February, 2016.

MICHAEL MALIHI, Judge