

State of Rhode Island  
Department of Health  
Board of Medical Licensure and Discipline



**IN THE MATTER OF:**  
**William H. Sabina, MD**  
**License No.: MD 09565**  
**Case Nos.: 190727, 190927; 191263; and 191264**

### **CONSENT ORDER**

William Sabina, MD ("Respondent") is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline ("Board") has reviewed and investigated the above-referenced complaints pertaining to the Respondent through its Investigative Committee. The Board makes the following

### **FINDINGS OF FACT**

1. Respondent has been a licensed physician in the State of Rhode Island since August 6, 1997. Respondent graduated from Boston University School of Medicine in 1995. Respondent's specialty is emergency medicine.
2. The Board received two complaints, 190727 and 190927, relative to Respondent's care as the attending physician for a minor patient—Patient A (alias). Both complaints involve the same incident. The first complaint (190727) was filed anonymously. The second complaint (190927) identified Patient A. For the purposes of this Consent Order, the two referenced complaints for this one incident will simply be referred to as "the complaint."
3. The complaint was reported to the Board by Dr. Lisa Rameka, Chief Medical Officer at South County Hospital ("South County"), based on allegations made by Patient A on June 4, 2019. The

complaint relays Patient A's allegation that the Respondent acted inappropriately during a December 12, 2001 visit to the South County emergency department.

4. Patient A acknowledges that she waited years before reporting Respondent's conduct, which delay she attributes to a variety of reasons, including her young age at the time and her lack of awareness relative to the need to report such matters to the Board.

5. South County was unable to furnish medical records for Patient A's December 2001 encounter. Nevertheless, the Investigative Committee obtained documents corroborating that Respondent saw Patient A in December 2001.

6. Respondent appeared before the Investigative Committee on November 7, 2019, at which time Respondent reported that he had no recollection of the December 2001 encounter.

7. The Board opened complaint 191263 pursuant to its review of Respondent's South County credentials file, which revealed that a complaint had been filed, the facts and circumstances of which had not had not previously been reported to the Board.

8. The complaint had been filed with South County in 1999 by a nurse—Nurse A (alias)—who worked with Respondent in the operating room on a case involving Patient B (alias), a male minor, who had been bitten by a dog; Respondent was Patient B's attending physician. In her handwritten complaint to her supervising nurse manager, Nurse A reported on Friday, October 22, 1999, a boy came to the South County emergency room with dog bit on his penis. According to Nurse A, Respondent "made inappropriate comments about this injury at the desk" and said "*Didn't the kid know he was supposed to stick it [the penis] in the other end [of the dog]?"*" A further reported that Respondent "*called the staff's attention and was about to repeat this comment again. I told him 'Don't say it' twice. He thought I was joking. I even put my hand over his mouth and told him to stop. Not only did he repeat the remark but he made another off-color remark because the dog was*

*a cocker spaniel.” Nurse A stated, “I find this behavior personally offensive.”*

9. In his October 15, 2019 written response to this complaint Respondent admitted *“I recall being advised after the incident that my supervisor had conducted an investigation and had spoken with other nurses who agreed that while I may have made a bad “joke” of the situation, they did not feel there was anything sexual in nature about my comments.”* Respondent continued, *“At the same time that I was advised of the outcome of the results of the investigation, my supervisor suggested that I be less friendly with the nurses as my mouth could get me into trouble (his words). I would point out that this was very early in my career. In fact, I was hired by South County Hospital in 1999, so this incident would have taken place during the first few months of my employment. I took my supervisor’s advice to heart and never had another problem with any allegations of inappropriate comments.”*

10. Respondent made similar comments at his November 7, 2019 appearance before the Investigative Committee, when he stated that he was young, immature, and had a *“gallows humor.”*

11. Pursuant to request of the Board, Respondent agreed to go to Acumen Assessments (“Acumen”) for a comprehensive forensic psychiatry evaluation. The Investigative Committee reviewed Acumen’s December 13, 2019 report on Respondent, which was based primarily on documentary information provided to Acumen by the Board relative to the above-referenced complaints and Acumen’s assessment of Respondent between November 11 and November 14, 2019.

12. The Acumen report stated that Respondent is *“a highly anxious, insecure, obsessive-compulsive, and detail oriented individual, who is currently overwhelmed with stress and worry stemming from the allegation made against him,”* and that Respondent *“is an individual who has had an exemplary career, and who takes considerable pride in his reputation and the*



*psychological testing profile corroborates this clinical observation. The allegations against him are having a significant negative impact on his identity and the reputation he has worked hard to obtain."*

13. The Acumen report noted that a forensic polygraph examination resulted in a finding of "No Significant Reaction." The Acumen report went on to state, *"This is a puzzling case. The assessment team does not question [Patient A's] experience . . . . However, it is difficult to determine the linkage between her and [Respondent] based on the absence of facts provided to the Board and the assessment team. This report is focused on making a fitness to practice determination regarding [Respondent] and is not a fact finding process."*

The Acumen assessment team concluded that the Respondent was fit to continue to practice medicine and recommended *"that [the Respondent] continue to practice all times in full accordance with relevant federal, state, local, organizational, and professional regulations, ethical guidelines, and best practices."*

14. The Investigative Committee reviewed the findings of Acumen, and from the Respondent, and documentation from Respondent's credentials file, which was available to Acumen.

15. Based on the foregoing, the Investigative Committee concluded that Respondent committed "unprofessional conduct," as defined in R.I. Gen. Laws § 5-37-5.1.


**Based on the foregoing, the parties agree as follows:**

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.
2. Respondent and the Board agree that this Consent Order is intended to dispose of all the case numbers referenced above.
3. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.

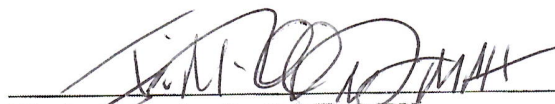

4. If ratified by the Board, Respondent hereby acknowledges and waives:
  - a. The right to appear personally or by counsel or both before the Board;
  - b. The right to produce witnesses and evidence on his behalf at a hearing;
  - c. The right to cross examine witnesses;
  - d. The right to have subpoenas issued by the Board;
  - e. The right to further procedural steps except for those specifically contained herein;
  - f. Any and all rights of appeal of this Consent Order;
  - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and
  - h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the Rhode Island Department of Health ("RIDOH") public website.
5. Respondent agrees to pay, within 5 days of the ratification of this Consent Order, an administrative fee of \$6,450.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "**Rhode Island General Treasurer**," and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this condition to [DOH.PRCompliance@health.ri.gov](mailto:DOH.PRCompliance@health.ri.gov) within 30 days of submitting the above-referenced payment.
6. Respondent hereby agrees to a reprimand and although he will maintain a physician's license to practice medicine in the State of Rhode Island, he agrees that he will no longer practice medicine within the State.

7. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have 20 days of the suspension and/or further discipline to request an administrative hearing. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 29<sup>th</sup> day of October, 2020.

  
William Sabina, MD

Ratified by the Board of Medical Licensure and Discipline on the 18<sup>th</sup> day of November, 2020.

   
Nicole Alexander-Scott, MD, MPH  
Director  
Rhode Island Department of Health  
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Providence, RI 02908