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

IN THE MATTER OF:
William Braden M.D.
License Number MD 04690
C170827, C170971, C180023

CONSENT ORDER

The Rhode Island Board of Medical Licensure and Discipline (hereinafter "Board") has reviewed and investigated the above referenced complaints pertaining to Dr. William Braden (hereinafter "Respondent") through its Investigative Committee and makes the following:

FINDINGS OF FACT

1. Respondent is a licensed physician in Rhode Island and was issued his license on April 24th, 1974.
2. Respondent's specialty is Psychiatry. Respondent is a graduate of Harvard Medical School.
3. Respondent was the attending physician for Patient A.
4. The Board received a complaint from a family member of Patient A regarding prescribing of controlled substances to Patient A. Complainant was concerned regarding Patient A receiving Valium, Fioricet, Prozac, trazadone and Adderall.
5. Patient A saw Respondent several times from 2013 to present. Respondent had a pattern of prescribing benzodiazepines in combination with a barbiturate as well as stimulants and multiple antidepressants to Patient A. Patient A was 73 at the time of the visit in 2013.
6. Patient A was treated with poly-pharmacy which presents safety risks to Patient A. Four of the medications Respondent prescribed to Patient A are medications that present

additional risk to elderly patients as recorded in the Beers list. These medications alone and in combination present risk to elderly patients of over sedation, increased risk of cognitive impairments, delirium, falls and fractures, as well as high rate of physical dependence.

7. There was no documentation in the medical record that the additional risks of these medications were discussed with Patient A.

8. The Investigative Committee further noted that although attempts were made to wean Patient A from the medication, it was not clear who was directing the care of Patient A, and it appeared Patient A was directing the care of her own treatment.

9. Respondent was the attending physician for Patient B.

10. The Board received a complaint from a family member of Patient B regarding prescribing of controlled substances to Patient B. Complainant was concerned regarding Patient B receiving high doses of benzodiazepines, specifically, clonazepam. Complainant noted Patient B had overdosed previously on clonazepam, and been admitted to Kent and Butler at different times for this pattern of misuse, yet Respondent continued to prescribe this medication without sufficient safeguards or consideration of other treatments.

11. Patient B saw Respondent several times from November 2016 until October of 2017. Patient B was seeing a primary care provider prior to seeing Respondent who maintained Patient B on clonazepam on .5 mg of clonazepam twice a day and monitored the patient closely.

12. Respondent assumed care of Patient B in November of 2016 and had a pattern of prescribing clonazepam, a benzodiazepine to Patient B and increased the dose to 1 mg twice a day and then to 1 mg three times a day. Patient B had a diagnosis of anxiety and attention deficit disorder.

13. Respondent prescribed 60 clonazepam 1 mg to Patient B on January 16th, 2017, with an expected days' supply of 30 days. A new prescription was given to Patient B for the same medication on February 12th, 2017, again for a 30 days' supply. Patient B called Respondent on February 15th and reported he lost the prescription. Respondent wrote a new prescription for this same medication on the 15th, which is 3 days later for another 30

days' supply. The PDMP recorded all 3 prescriptions as being dispensed and this information was available contemporaneous with the prescriptions being written.

14. Patient B's mother called Respondent in February and told Respondent Patient B was admitted to Kent due to overdose of clonazepam. Patient B saw Respondent again May 18, 2017, and the matter of filling additional prescriptions and the subsequent admission to Kent was not discussed, rather the dose of clonazepam was increased to 75 tablets for a 25 days' supply, or 3 tablets a day. The progress notes from the May 18, 2017 office visit state in the history "He's continued to do well on the meds" …." but if he has a bad day he takes one in the middle of the day, but then he is short".

15. The investigative committee concluded Patient B was not monitored closely regarding his benzodiazepine usage.

16. The investigative committee interviewed Respondent and informed him he was the number one prescriber of benzodiazepines in Rhode Island. Respondent could not articulate a reason for this. Respondent did not at that time articulate a clear plan to change this pattern. Respondent did not endorse other treatments for anxiety as being as effective compared to benzodiazepines. Respondent was the attending physician for Patient A. The Investigative Committee concluded Respondent over prescribed benzodiazepines.

17. Respondent was the attending physician for Patient C.

18. The Board received a complaint that Patient C was being prescribed Vicodin® from Respondent since 2010. Complainant alleges Patient C took some of the Vicodin® and sold the rest. Vicodin® is a schedule 2 opioid and a controlled substance. Respondent also prescribed clonazepam, a benzodiazepine to Patient C.

19. The Investigative committee reviewed the medical records and determined Respondent did prescribe Vicodin® at regular intervals to Patient C. Respondent did maintain a medical record. The Investigative committee did not see that Respondent was regularly reviewing the PDMP, obtaining regular urine drug screens or utilizing adequate safeguards to prevent diversion. The Investigative committee did note Patient C was positive for cocaine on at least one occasion, yet there was not adequate follow up.

20. Respondent violated RIGL § 5.37.5.1(19) defined as: *Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision*

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board, and this Consent Order is not binding on Respondent until final ratification by the Board.

3. 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; and

   g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.

   h. Any objection that this Consent Order will be reported to the National Practitioner Data Bank, Federation of State Medical Boards as well as posted on the department's public web site.

4. Respondent agrees to pay upon ratification of this Consent Order an administrative fee to the Board with a check for $1700 dollars made payable to

the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint.

5. . Respondent will document in the medical record and discuss risk and benefits of all medications to all patients.

6. Respondent will complete a 15 hour category 1 approved CME home study in anxiety as well as a 20.25 hours of Board approved CME in matters related to the treatment of anxiety and benzodiazepine prescribing.

7. Respondent will retain a Board approved monitor to review 10 medical records monthly and appropriateness of treatment for the next 12 months (if reports are favorable then 10 medical records quarterly for the next 24 months).

8. Respondent will be on probation for 3 years.

9. Respondent will send notice of compliance with all conditions of this order to DOH.PRCompliance@health.ri.gov within 30 days of satisfying each condition.

10. Respondent hereby agrees to this reprimand on his physician license.

11. Within 150 days of ratification of this order, Respondent will cease prescribing opioids, specifically schedule II and III opioids, except buprenorphine (Suboxone® and others) used for treatment of addiction.

12. If any term of this Consent Order is violated, after it is signed and accepted, the Director of the Department of Health shall have the discretion to impose further disciplinary action including immediate suspension. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request a hearing within twenty (20) days of the suspension and/or further discipline. The Director of the Department of Health shall also have the discretion to request a hearing after notice to Respondent of a violation of any term of this Consent Order. After hearing thereon, the Board may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if any alleged violation is proven by a preponderance of evidence.

Signed this 4 day of May (WB) 2018.

William Braden, M.D.

Ratified this 15th day of May 2018 by the Board of Medical Licensure and Discipline.

Nicole Alexander-Scott, M.D., M.P.H.
Director
Rhode Island Department of Health
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Providence, Rhode Island 02908