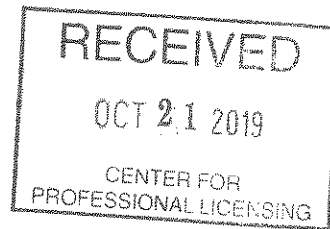


State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline



IN THE MATTER OF:
William Palumbo, MD
License No.: MD 07181
Case No.: C19-0502

CONSENT ORDER

William Palumbo, MD (“Respondent”) is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline (“Board”) makes the following

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since October 7, 1987. Respondent graduated from the University of Rome on June 1, 1984.
2. On April 15, 2019, the Board received a complaint from a Massachusetts pharmacist (“Complainant”), alleging that Respondent was inappropriately prescribing controlled substances to a patient who was also Respondent’s co-worker (“Medical Assistant”).
3. Complainant reported calling Respondent’s office several times regarding these prescriptions, which were confirmed as accurate by the office staff. It was later learned by the Investigative Committee that the accuracy of these prescriptions was confirmed by Medical Assistant, herself.
4. Complainant reported becoming suspicious, which prompted Complainant to contact Medical Assistant’s gastroenterologist. Complainant reported that Medical Assistant’s

gastroenterologist was unaware of the various controlled substance prescriptions and was also concerned. Thereafter, Complainant reported this matter to the Board.

5. Respondent practices as a primary care provider in a group medical practice, Comprehensive Health Care, located at 1637 Mineral Spring Avenue, North Providence.

6. Medical Assistant is a 32-year-old female, formerly employed by Comprehensive Health Care, where she was assigned to work with Respondent as a medical assistant. In his September 25, 2019 appearance before the Investigative Committee, Respondent reported that Medical Assistant was very good at her job and that he considered her a very good co-worker and a friend.

7. After reviewing the complaint against him, Respondent worked with leadership at Comprehensive Health Care office to determine what had happened. Respondent stated emphatically that he did not prescribe these medications to Medical Assistant. The Board obtained via subpoena the actual prescriptions, which Respondent reviewed and stated are forgeries that he did not sign. The Investigative Committee agreed that the prescriptions were forged.

8. Respondent also reviewed the relevant PDMP after becoming aware of this complaint and was able to review all the prescriptions written in his name.

9. At his September 25, 2019 appearance, Respondent admitted that he had not, himself, checked the PDMP previously. Rather, Medical Assistant did this for him. Respondent admitted that he gave Medical Assistant his user name and password for the PDMP and that Medical Assistant conducted all PDMP reviews for him. Respondent was unaware that Medical Assistant should not have been given his user name and password, but, rather, should have had her own user name and password as a delegate.

10. The PDMP automatically sends clinical alerts for high-risk drug combinations. Clinical alerts were sent to Respondent regarding overlapping prescriptions for opioids and benzodiazepines on five separate occasions between February of 2019 and March 6, 2019. Respondent stated that he did not receive these clinical alerts because he had allowed his PDMP registration to be connected to Medical Assistant's email address. Respondent admitted to the Investigative Committee that he was not savvy with computers and other technology and that, at the time, this arrangement had seemed like a good idea to him. Respondent was unaware that he could have a delegate for the PDMP and that delegates must have their own user names and passwords.

11. Since April 24, 2018, Medical Assistant forged 26 prescriptions, which included 1,440 doses of oxycodone (a schedule II opioid), 402 doses of various benzodiazepines, and 600 doses of Adderall (stimulant).

12. The Board received a statement in support of Respondent from the office manager of Comprehensive Health Care, in which the office manager admitted that, at the time, the office's prescription pads were not securely stored and that the office has changed its policy on prescription pad security. Respondent admitted that he did not have prescription pads securely stored, as well.

13. The Investigative Committee concluded that Respondent acted negligently in giving Medical Assistant his user name and password to the PDMP, which facilitated his lack of awareness of the PDMP clinical alerts sent to him, which would have alerted him to the diverted controlled substances by Medical Assistant, and also in using her email address for receipt of clinical alerts. The Investigative Committee also concluded that Respondent acted negligently in failing to secure his prescription pads, which is the duty of every licensed prescriber. The

Investigative Committee concluded Respondent failed to meet the minimum standards to prevent diversion of controlled substances.

14. The Investigative committee concluded that Respondent violated R.I. Gen. Laws § 5-37-5.1(19), which defines “unprofessional conduct” as including, “[i]ncompetent, 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.”

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

h. Any objection 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.

4. Respondent agrees to pay, within five days of the ratification of this Consent Order, an administrative fee of \$1050.00 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.PRCCompliance@health.ri.gov within 30 days of submitting payment.


5. Respondent agrees to this reprimand on his physician license.

6. Respondent shall remain on probation three years from ratification of this order. If there are no violations during this three-year period, the probation will expire without further notice from the Board.

7. In the event that 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 the right to request an administrative hearing within 20 days of the suspension and/or further discipline. 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 Board 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.

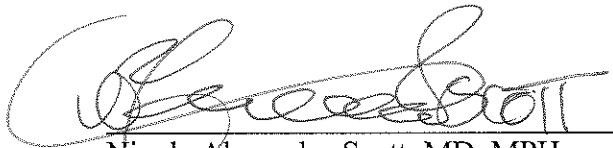
[SIGNATURE PAGE FOLLOWS]

Signed this 17 day of October, 2019.



William Palumbo, MD

Ratified by the Board of Medical Licensure and Discipline on the 13th day of November 2019.



Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908