BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF ARIZONA

In the Matter of **ROBERT A. WILLIAMS, M.D.** Holder of License No. **12287** For the Practice of Medicine In the State of Arizona. Re: L.M.S. v. Robert A. Williams, M.D. (Inv. #10352)	**CONSENT AGREEMENT TO LETTER OF REPRIMAND**

ROBERT A. WILLIAMS, M.D., holder of License No. 12287 for the practice of medicine in the State of Arizona, and the Arizona Board of Medical Examiners ("Board") hereby agree as follows:

1. Pursuant to A.R.S. §32-1451(F)(5), Dr. WILLIAMS agrees that the Board shall adopt the Letter of Reprimand, Findings of Fact, Conclusions of Law, and Order attached to this Consent Agreement and incorporated by this reference. The Letter of Reprimand shall be effective on the date written on the letter. Dr. WILLIAMS agrees that the Board has substantial evidence in support of the Findings of Fact and Conclusions of Law. He agrees not to contest the accuracy of the Findings of Fact and Conclusions of Law.

2. By entering into this Consent Agreement, Dr. WILLIAMS freely and voluntarily relinquishes all right to an Informal Interview before the Board, a hearing before a hearing officer and before the Board, and relinquishes all right of rehearing, review, reconsideration, appeal, judicial review or any other judicial action concerning the matters set forth herein. Dr. WILLIAMS affirmatively agrees that the Letter of Reprimand shall be irrevocable.

3. Dr. WILLIAMS has read and understands the Consent Agreement, Letter of Reprimand, Findings of Fact, Conclusions of Law, and Order, and voluntarily enters

into this Consent Agreement. Dr. WILLIAMS understands that he may consult legal counsel regarding this matter and agrees that he has done so or affirmatively declines to do so.

4. The Consent Agreement, Letter of Reprimand, Findings of Fact, Conclusions of Law and Order, if adopted by the Board, constitute a resolution of the following case: L.M.S. vs. Robert A. Williams, M.D. (Investigation No. 10352). The Consent Agreement, Letter of Reprimand, Findings of Fact and Conclusions of Law do not constitute a dismissal or resolution of any other matters currently pending and do not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action, or proceeding.

5. The Consent Agreement, Letter of Reprimand, Findings of Fact, Conclusions of Law, and Order shall not become effective until adopted by the Board and signed by the Board's Executive Director.

6. Dr. WILLIAMS understands that if the Board does not adopt the Consent Agreement, Letter of Reprimand, Findings of Fact, Conclusions of Law, and Order, the case listed in paragraph 4 above will be decided by the Board pursuant to the Medical Practice Act, A.R.S. § 32-1401 et seq. Dr. WILLIAMS agrees that he will not assert as a defense that the Board's consideration of the Consent Agreement, Letter of Reprimand, Findings of Fact and Conclusions of Law constitutes bias, prejudice, prejudgment or other similar defense.

7. The Consent Agreement, Letter of Reprimand, Findings of Fact and Conclusions of Law is a public record and shall be reported as required by law to the National Practitioner Data Bank and also to the Federation of State Medical Boards.

8. The Consent Agreement constitutes the entire agreement of the parties.

9. Any violation of this Consent Agreement or the Letter of Reprimand constitutes unprofessional conduct pursuant to A.R.S. §32-1401(25)(r) (Violating a formal order, probation or stipulation issued or entered into by the board or its executive

director under the provisions of this chapter) and may result in disciplinary action pursuant to A.R.S. §32-1451.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

Donna M. Nemer RN
DONNA M. NEMER, R.N.
Acting Deputy Director

Dated: 5-26-98

Robert A. Williams MD
ROBERT A. WILLIAMS, M.D.

Dated: 5-11-98

ORIGINAL of the foregoing Consent Agreement to Letter of Reprimand and Copy of Letter of Reprimand mailed by Certified Mail this 8th day of May, 1998 for **signature** to:

Robert A. Williams, M.D.
(Address of Record)

Merrie Jo Hamilton
Secretary

COPY of the foregoing **signed** Consent Agreement to Letter of Reprimand and Letter of Reprimand mailed this 27th day of MAY, 1998 to:

Robert A. Williams, M.D.
(Address of Record)

Merrie Jo Hamilton
Secretary

981110006/vmm/dse

ARIZONA BOARD OF MEDICAL EXAMINERS

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

Certified Mail/Return Receipt Requested

Robert A. Williams, M.D.
Address of Record

Re: **LETTER OF REPRIMAND**
L.M. v. Robert A. Williams, M.D.
(Investigation No. 10352)

Dear Dr. Williams:

You have agreed in the Consent Agreement attached to this letter that the Arizona Board of Medical Examiners shall resolve the complaints listed above by issuing a Letter of Reprimand to you.

A Letter of Reprimand is defined in A.R.S. § 32-1401(15) as "a disciplinary letter issued by the Board that informs the physician that the physician's conduct violates state or federal law but does not require the Board to restrict the license or monitor the physician because the physician's conduct did not harm a patient or the public."

In voting to issue the Letter of Reprimand, the Board adopted the following Findings of Fact, Conclusions of Law, and Order.

Findings of Fact

1. The Board of Medical Examiners of the State of Arizona is the duly constituted authority for the regulation and control of the practice of medicine in the State of Arizona.

2. Robert A. Williams, M.D. is the holder of License No. 12287 for the practice of medicine in the State of Arizona. He practices as a psychiatrist.

3. In the course of the investigation into a complaint by patient L.M., the Board determined that Dr. Williams' medical records on this patient were incomplete and inadequate, and directed staff to review ten other patient charts chosen at random to determine the quality of Dr. Williams' patient records.

4. Patient B.D., a 22-year-old male, was initially seen by Dr. Williams on 6-25-97 for gambling and suspected depression. Dr. Williams' records do not delineate depressive symptomatology. The records make only a vague reference to the criteria being satisfied for depression under the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) and indicate the patient may also have Attention Deficit Disorder. Dr. Williams' records make reference to the use of alcohol three weeks earlier but there is no information regarding the extensiveness of that use. Dr. Williams' assessment was gambling addiction, and he prescribed Prozac and Dexedrine for depressive reaction. There was no documentation within the record regarding the benefits, risks and alternatives being discussed with regard to the medications, and no documentation that the patient was asked about other substances being used in light of the prescription of Dexedrine.

5. Patient S.A., a 23-year-old female, was initially seen by Dr. Williams on 6-19-97. Dr. Williams' records indicate the patient had chronic residual depression with exacerbation. There is no delineation of the symptomatology of the depression. Dr. Williams' diagnosis was major depression recurrent, question bipolar disorder even though his notes state that there is no history of mania. Subsequent notes of Dr. Williams do not indicate how the patient was functioning. Dr. Williams made changes to the treatment protocol without documentation as to why these changes were made. Dr. Williams' records use letters of the alphabet to apparently indicate symptoms, but there is no corresponding ledger to explain what the letters mean.

6. Patient E.C., a 34-year-old male, was seen by Dr. Williams on 6-6-97 for depression and substance abuse. Dr. Williams' records note that the patient reported drinking 6-8 drinks per week, yet use of alcohol was not further evaluated, nor was the patient's reported use of marijuana evaluated. The patient's presenting history was recorded as mood swings with a residual chronicity and depression, although the depression is not defined. Dr. Williams indicates that the patient meets the criteria for major depression in the DSM IV, yet the specific criteria were not listed. Dr. Williams prescribed large amounts of medications with no documentation that the benefits, risks and alternatives were discussed with the patient.

7. Patient K.K. was seen initially by Dr. Williams on 8-5-96 for anxiety. Dr. Williams did not initially record any symptomology of the patient's anxiety. Dr. Williams' assessment was panic anxiety disorder reportedly activated with thyroid replacement. Subsequent notes regarding the patient's neurological status are incomplete.

8. Patient C.H., a 38-year-old male, had a history of depression and testosterone replacement therapy. Dr. Williams indicates that the patient satisfies the DSM IV criteria for major depression, although there is nothing documented in the records to support the diagnosis. Dr. Williams also diagnosed C.H. with bipolar disorder yet there is no documentation within the record that he meets the criteria for this diagnosis.

9. Patient K.G. was initially seen by Dr. Williams on 4-15-97 for treatment for Attention Deficit Hyperactivity Disorder (ADHD). Dr. Williams' records state that the patient meets the criteria for ADHD, although these criteria are not defined. The records also note that the patient meets 5 of the 9 criteria for major depression under the DSM IV, yet the criteria are not listed. In addition to ADHD and major depression, Dr. Williams diagnosed K.G. with obsessive tendencies and allergies. Dr. Williams initially prescribed Ritalin and Zoloft for the patient and later changed to Atarax and Clonidine. Dr. Williams' follow-up psychiatric and neurological exams on the patient are incomplete. Dr. Williams' records do not document the benefits, risks and alternatives of the medications he prescribed for the patient. Dr. Williams did not document any laboratory data regarding the patient's Clonidine use.

10. Patient M.R. saw Dr. Williams for irritability. Dr. Williams diagnosed the patient with bipolar disorder and started him on Depakote. Dr. Williams' records do not adequately document the patient's symptomatology for bipolar disorder. Dr. Williams' neurological examination of the patient was incomplete. Dr. Williams' notes often indicate improvement without giving any details and without completing psychiatric or neurological examinations. Dr. Williams made changes to the patient's medications without documentation as to the reasons for the medication changes, the protocol Dr. Williams' was following, or that the risks, alternatives and benefits had been explained to the patient.

Conclusions of Law

1. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(e) (failing or refusing to maintain adequate records on a patient).

Order

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ordered that Robert A. Williams, M.D. be issued a Letter of Reprimand.

DATED this 26th day of May, 1998.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

[SEAL]

By Donna M. Nemer, RN
DONNA M. NEMER, R.N.
Acting Deputy Director

981040010/vmm/dse

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

ROBERT WILLIAMS, M.D.

Holder of License No. **12287**
For the Practice of Medicine
In the State of Arizona.

Board Case No. MD-01-0661

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand and Probation)

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on August 7, 2002. Robert Williams, M.D., ("Respondent") appeared before the Board with legal counsel Dan Jantsch for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 12287 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-01-0661 after receiving a complaint alleging that Respondent did not make consistent entries in the chart of a female patient ("L.F.") concerning Respondent's treatment of L.F.

4. An outside medical consultant reviewed L.F.'s records and stated that Respondent's record keeping was substandard, minimal and barely legible. Upon receiving the Medical Consultant's opinion regarding Respondent's record keeping, Board investigative Staff conducted a random sampling of Respondent's charts. A

second Board Medical consultant reviewed seven of Respondent's charts and opined that the charts were missing information, had poor overall documentation and the review of the random charts suggested a pattern of behavior.

5. Respondent testified that his was a referral practice for treatment resistant patients, for patients who have sleep disorders or unusual overlapping psychiatric syndromes. Respondent testified that he had a tremendous connection to the community, including other psychiatrists, psychologists, and internal and general medicine physicians and he had received very few complaints about his records in terms of the narrow focus of either diagnosing a sleep disorder or for focusing on sleep resistance.

6. At the formal interview Respondent admitted that characterizing his charts as "sparse" was a fair assessment. Respondent was asked about some of the first Medical Consultant's objections to his records, including that his writing was brief and barely legible and that his records did not give a clear picture of the physical and mental state of the patient at the time of the office visit. Respondent stated that some of the Medical Consultant's objections were justified. Respondent also stated that he had tried hard to upgrade his records after a 1998 Board action and that he was surprised by the Board's current criticisms.

7. Respondent was then asked to look at a February 26, 1998 chart entry in L.F.'s chart, and whether that entry indicated L.F.'s current level of functioning. Respondent stated that the psychiatric examination was coded and indicated L.F.'s appearance, mood, affect and motor level were normal. Respondent was asked if he believed that it was reasonable psychiatric practice to provide in the patient records some statement about how the patient is doing, for instance, address the patient's sleep pattern, appetite, libido and energy level. Respondent stated that if a patient is stable

from a biological point of view, illness behavior is not interfering with personality behavior, the patient's outward behavior reflects their normal level of functioning, and the symptoms listed would not be present. Respondent stated that within his practice of biological psychiatry when a person is stable it means that the illness behavior is under control, not interfering with the personality. Respondent indicated that he was sensitive to the concerns of the reviewing Medical Consultants and is trying to improve his records.

8. Respondent was asked about the Medical Consultant's criticism that there was no treatment plan for L.F. Respondent stated that the treatment plan in his clinic is to target illness behavior or illness, whether sleep disorder, anxiety disorder, obsessive/compulsive disorder or mood disorder. The treatment plan is a medical plan to control the symptoms of the illness so that the patient's outward behavior reflects their personality. Respondent agreed that his records would be obscure to someone who picked them up and attempted to determine L.F.'s current symptoms, current level of functioning and treatment plan.

9. Respondent was asked to identify how his practice and records had changed in the subsequent time since he treated L.F. Respondent stated that he is desperately trying to document things so that what he does is clear to everyone and not just himself.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 3, 4, 6 and 8 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(e) ("[f]ailing or refusing to maintain adequate records on a patient").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. Respondent is issued a Letter of Reprimand for failure to maintain adequate records on a patient.

2. Respondent is placed on Probation for two years with the following terms and conditions:

(a) Respondent shall, at his own expense, obtain the services of a Board-Staff pre-approved Office Practice Management Consultant to conduct an evaluation of Respondent's record keeping practices. Respondent shall authorize the Office Practice Management Consultant to forward a copy of the evaluation with findings and recommendations to the Board. Respondent shall provide the Office Practice Management Consultant with a copy of this Order. Board Staff shall review Respondent's records within at least six months, but no longer than 12 months after the Consultant concludes the evaluation. Based upon the office review the Board retains jurisdiction to take additional disciplinary or remedial action.

(b) Respondent shall pay the costs associated with monitoring his probation as designated by the Board each and every year of probation. Such costs may be adjusted on an annual basis. Costs are payable to the Board no later than 60 days after the effective date of this Order and thereafter on an annual basis. Failure to pay these costs within 30 days of the due date constitutes a violation of probation.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 3rd day of October, 2002.

ARIZONA MEDICAL BOARD

By Barry Cassidy
BARRY A. CASSIDY, Ph.D, PA-C
Executive Director

ORIGINAL of the foregoing filed this 3rd day of October, 2002 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

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Executed copy of the foregoing
mailed by U.S. Certified Mail this
30th day of October, 2002, to:

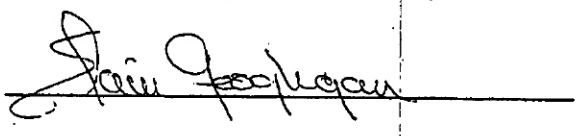
Dan Jantsch
Olson Jantsch & Bakker PA
7243 N. 16th St.
Phoenix, Arizona 85020-7250

Executed copy of the foregoing
mailed by U.S. Mail this
30th day of October, 2002, to:

Robert Williams, M.D.
5133 N Central Ave Ste 107
Phoenix, Arizona 85012-1438

Copy of the foregoing hand-delivered this
30th day of October, 2002, to:

Christine Cassetta
Assistant Attorney General
Sandra Waitt, Management Analyst
Lynda Mottram, Senior Compliance Officer
Investigations (Investigation File)
Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
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Website: www.azmdboard.org • Email: questions@azmdboard.org

January 31, 2005

Robert Williams, M.D.
5133 N. Central Avenue, Suite #107
Phoenix, AZ 85012-1438

RE: 11/02/02 Findings of Fact, Conclusions of Law and Order
MD-01-0661 (License #12287)

Dear Dr. Williams:

This letter confirms your probationary period in the above-referenced case has been completed according to the term of your Order. The probationary status of your license is hereby terminated. A copy of this letter has been placed in your license file.

Thank you for your cooperation regarding this matter. If you have any questions, please contact Paula Arcuri, Senior Compliance Officer, at (480) 551-2745.

Sincerely,

Timothy C. Miller, J.D.
Executive Director

TCM:pa

C: File
Licensing File