

**State of New Hampshire
Board of Medicine
Concord, New Hampshire**

In the Matter of:

Docket No.: 15-09

**Christopher Clough, P.A.
License No.: 0441**

ORDER

This case involving Christopher Clough, P.A. ("Mr. Clough," "Licensee" or "Respondent") arises out of a docket (No. 14-03) that was initiated in August 11, 2015 through a Notice of Hearing related to care that was being provided by the licensee to various patients. The procedural history of that case will not be reiterated here, except to note that during a prehearing conference on August 28, 2014 the licensee agreed to abide by certain restrictions during the pendency of the case. The restrictions included the need for the licensee to have all of his patient procedures "preapproved by his Registered Supervisory Physician (RSP) or his Alternate Registered Supervisory Physician (ARSP)."

The preapproval process required various reviews by the RSP or ARSP prior to the licensee performing pain procedures and also required "a telephonic or face-to-face consultation between the licensee and the RSP or ARSP," along with other documentation requirements. See Notice to Show Cause dated November 13, 2015 in Docket No. 15-09.

In an effort to ensure compliance with the practice restrictions, Board investigators conducted an unannounced inspection of the licensee's work-place and obtained records of 20 patients seen by the licensee for the period September 8, 2014 through November 13, 2014. A review of those records conducted by the Medical Review Subcommittee (MRSC) revealed concerns about the licensee's records and based on the information disclosed it appeared that the licensee may have engaged in professional misconduct by failing to comply with the terms of the practice restrictions.

The Notice of Hearing indicated that the Respondent could be subject to discipline.¹ The hearing was ultimately held on February 3, 2016. Dr. Conway, physician member of the MRSC, presented the case on behalf of the Board. Exhibit 1 was the MRSC Report of Investigation (ROI). The ROI contained specific findings regarding alleged lack of documentation by the Respondent with regard to preapprovals by RSP or ARSP. The pertinent patient records of 20 patients were marked as Exhibits 2 A through T. An evaluation sheet was also produced for patients and marked as Exhibits 5 A through S.

¹ The Notice inadvertently indicated RSA 329:17, VII was the operative statute for the hearing. The operative statute for Physician Assistants, however, is RSA 328-D: 6 and 7 which are in all material respects similar to RSA 329:17 and 18. Respondent, who was represented by counsel, did not move for clarification or request a change to the notice of hearing. Given that the Board can only discipline Physician Assistants pursuant to RSA 328-D, it is this statutory framework that will be evaluated here. Respondent was on notice of the operative facts and had access to the particular patient records.

These evaluation sheets listed a series of confirmations where the reviewing MRSC member, Dr. Conway, confirmed the following:

- Whether the Procedure was Pre-approved by the RSP or ARSP
- Whether RSP or ARSP reviewed the patient's history
- Whether RSP or ARSP reviewed diagnostic imaging and pertinent laboratory data
- Whether RSP or ARSP reviewed documented plan of action
- Whether a telephonic or face-to-face consultation occurred between Respondent and RSP or ARSP
- Whether there was confirming documentation in the medical record by RSP or ARSP
- Whether any prescriptions written by Respondent were reviewed in-writing post-issuance

The evaluation sheets corresponded to each patient.

Respondent testified on his own behalf at the hearing and presented Exhibits which included the following:

- Exhibit A – 9/4/2014 Prehearing Conference Order, Docket #14-3
- Exhibit B – 9/8/14 Addendum to Prehearing Conference Order, Docket #14-3
- Exhibit C – Exemplar of Screen Shots in "Hold" Status
- Exhibit D – Exemplar of Screen Shots in "Flag" Status
- Exhibit E – Patient Chart Access for Patient D.D. from 10/8/14 to 11/3/14
- Exhibit F – Patient Chart Access for Patient D.M. from 10/2/14 to 10/15/14
- Exhibit G – 11/7/14 Note, Patient B.S.
- Exhibit H – 11/12/14 Note, Patient T.B.
- Exhibit I – 11/14/14 Note, Patient D.B.
- Exhibit J – 10/30/14 and 11/3/14 Notes, Patient C.C.
- Exhibit K – 9/29/14 Note, Patient T.H.
- Exhibit L – Patient Chart Access for Patient T.H. from 9/29/14 to 10/29/14
- Exhibit M – 10/28/14 and 11/13/14 Notes, Patient K.S.
- Exhibit N – Affidavit of Dr. David Tung

The Respondent also filed a Post Hearing Submission on March 1, 2016 which indicated that the MRSC report was incorrect in its findings in a number of areas, and also argued that there was no evidence establishing an intentional failure to comply with Board Orders.

The Board assessed the credibility of the two witnesses and found Mr. Clough less than forthcoming. Counsel for Mr. Clough attempted to show that Mr. Clough complied or "substantially" complied with the Board's ordered practice restrictions. Evident, however, in the record is the fact that there is an absence of documentation that Mr. Clough and his RSP or an ARSP engaged in telephonic

conversations or face-to-face consultations with regard to the pre-approval process. While it is true, the practice restrictions, by Order dated September 8, 2014, were amended to make clear that the RSP or ARSP need not meet with the patient, this nevertheless did not change the requirement that Mr. Clough was required to communicate with his RSP or ARSP and that communication should have been reflected in the patient's Electronic Medical Record (EMR). The electronic signing off of the RSP on the EMR does not substantiate active communication. It only demonstrates that the RSP reviewed the record and approved the procedure.

Dr. Tung's explanation, through his affidavit, of the "hold" and "flag" process was not persuasive to indicate that actual "consultation" occurred. Dr. Tung's affidavit describes that electronic notes were used to pass information along. Dr. Tung then states that where he signed the note electronically he was "documenting that upon consultation with Mr. Clough, [he] had approved the procedure." The statement does little to persuade the Board that a face-to-face or telephonic exchange of information occurred between Mr. Clough and Dr. Tung.

For example, in the upwards of 20 records that were reviewed not one record clearly indicates anything more than an after the fact signing of the electronic record, for the pre-procedure reviews, demonstrating that no "consultation" type dialogue took place. The W.B. patient record was at best unclear where it indicated that Dr. Tung reviewed the use of conscious sedation where the patient indicated he had a fear of needles and procedures. Other records such as the CC patient records were clearer and indicated that the RSP actually signed the pre-procedure plan after the actual procedure. Exhibits 2E and J show that Dr. Tung reviewed an office visit of 10/30 on 11/4/14 where he agreed that the patient should be weaned down on total dosing of opioids. The problem, however, was that there was a planned procedure entered in the record on 11/3 for an injection procedure to take place on 11/7, but the record was not electronically signed by Dr. Tung until 11/10.

Likewise, there was no record of actual face-to-face or telephonic “consultation” regarding patient F.S. The exhibits show that an injection procedure with sedation was to occur on 10/22/14. The record was electronically reviewed by Dr. Tung the same day, 10/22. The same is true with patient W.N.; the pre-procedure note was not signed by Mr. Clough’s RSP or ARSP and the procedure note was signed by Dr. Tung on the day of the procedure, after it was completed. Additionally, there is no evidence that any form of consultation occurred for patient D.M. on the planned injection for 10/15. The only electronic signature by the RSP came on 10/15 after the injection. Respondent’s Exhibit F shows that Dr. Collins accessed the chart, but there is no electronic signature on the chart itself. Nothing indicates that Dr. Collins, in fact, “consulted” with Mr. Clough.

In one instance Dr. Conway’s evaluation report indicated that patient B.S.’s chart was not signed where patient B.S. was seeing the Respondent on 11/7/14 for medication management. Respondent’s Exhibit G, however, compared to Exhibit 2R, was a different chart for patient B.S and it showed electronic signatures by Mr. Clough on 11/18 at 7:30 a.m. and the RSP on 11/19 at 2:08 a.m. There was no tangible explanation given for the discrepancy. The Board, however, does not place its findings on this issue alone. In another instance a new Percocet prescription for B.P. was not reviewed by the RSP or the ARSP. There was no explanation for this “oversight.”

It is the totality of the problems that lead the Board to its decision that Mr. Clough did not comply with the requirement to engage in face-to-face or telephonic consultations with his RSP or ARSP prior to performing injections. Whether the failure was “intentional” or not is not of any significance in this case. The Board placed the practice restrictions on Mr. Clough as a result of the allegations of improper prescribing and inappropriate injection procedures. His practice and the manner in which he continued to provide treatment without having a live-time dialogue with his RSP or ARSP leaves the Board concerned with his ability to follow requirements necessary to ensure patient safety. The failure to meet the restrictions also further diminishes the Board’s confidence in Mr. Clough’s ability to practice

as a physician assistant in New Hampshire. This failure constitutes unprofessional conduct under RSA 328-D:6. Pursuant to RSA 328-D:7, Mr. Clough's license is hereby REVOKED.

BY ORDER OF THE BOARD*

DATED: 12/8/2016

Penny Taylor

Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine

*Robert Andelman, M.D. and Louis Rosenthal, M.D., Board Members, recused. Frank B. Dibble, Jr., M.D. and Daniel P. Potenza, M.D. abstained.