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

IN THE MATTER OF:
Anthony Farina, MD
License No.: MD 08466
Case Nos.: 180165, 180597, 180890, 180704, 190616, 190654, 190645, 190622, 201005, 201737, 201755, 201756, and 201758

SUMMARY SUSPENSION

The Rhode Island Board of Medical Licensure and Discipline ("Board") has reviewed and investigated the above-referenced complaints pertaining to Dr. Anthony Farina ("Respondent") through its Investigative Committee. These complaints are now forwarded emergently to the Director ("Director") of the Rhode Island Department of Health ("RIDOH") following the Investigative Committee meeting of January 7, 2021.

The Investigative Committee has determined that the four most recent complaints—201737, 201755, 201756, and 201758—demonstrate that Respondent is an immediate danger to the public and should be summarily suspended.[1] Additionally, the Investigative Committee has considered the nine preceding complaints, which complaints reveal a pattern of misconduct that, in connection with the four most recent complaints, enhance the Investigative Committee's sense of urgency, that Respondent is an immediate danger to the public. Indeed, the Investigative Committee members noted that Respondent's overall pattern of misconduct is unprecedented in the history of this Board. The Investigative Committee does not have the authority to summarily

[1] The findings of fact relevant to the four most recent complaints are set forth in ¶¶ 54-66, herein.

suspend a license. That authority rests solely with the Director. Hence, this emergent recommendation to the Director.

FINDINGS OF FACT

1. Respondent graduated from Brown University School of Medicine on June 1, 1991 and has been a licensed physician in the State of Rhode Island since August 4, 1993. Respondent's primary specialty is Internal Medicine. According to the Rhode Island Secretary of State website, Respondent is the director/president of at least six medical corporations: (1) Center of New England Primary Care, Inc. (2) Center of New England Urgent Care, Inc. ("CNEUC"), (3) Physicians Weight Loss & Medical Services, Inc., (4) North Providence Primary Care Associates, Inc. ("NPPC"), (5) North Providence Urgent Care, Inc. ("NPUC"), and (6) East Greenwich Urgent Care, Inc. The listed address for all but the Physicians Weight Loss & Medical Services, which is 1963 Central Avenue, Johnston, RI, is 1830 Mineral Spring Avenue, North Providence, RI.

2. On February 9, 2018, the Board received complaint 180165 from Patient A (alias)—an NPPC patient—alleging that he had been unable to have his medical records forwarded by Respondent to another physician.

3. In the complaint, Patient A stated, "*I sent a release form to [Respondent]'s office for my medical records and my new physician has sent multiple requests as well. We still have not received my medical records*."

4. The Investigative Committee obtained a copy of the medical records release, signed by Patient A and dated July 12, 2017, which was sent from the requesting physician office,.i.e., Coastal Medical, to Respondent. The release authorizes the transfer of medical records, including, among other things, "Abstract of the last 2 years for continuation of care," "Complete

record," "Consultation notes," "Laboratory studies," and "X-ray reports."

5. On May 14, 2018, the Board received complaint 180597 from Patient B (alias) relative to Respondent's failure to transfer her medical records and those of her spouse, Patient C (alias), to another physician; Patient B and C are NPPC patients. Patient B stated, "*I have requested several times in person and faxed requests to [Respondent]'s office to have my medical records and my husband's . . . medical records transferred to [m]y new primary care physician ("PCP") . . . . On February 2, 2018 [my new PCP]'s office again faxed a request for these records. I was told they had 30 days to do so – and 30 days have certainly passed. I have made several office visits to [Respondent]'s office to request these records and have been told that Stephanie, the office manager, is responsible for such requests. She has refused to come to the front desk to speak with me on each occasion. She tells the receptionist that she's in a meeting when I can actually see her walking around the office. I have waited in the waiting room on two separate occasions for over two hours to speak with Stephanie. She refuses to speak with me. I have asked to speak with [Respodent], and that's also impossible. As of today, [our] medical records have not been transferred. We have our annual physicals scheduled for May 24, 2018. This avoidance leads me to think that our medical records are lost.*"

6. Respondent appeared before the Investigative Committee on September 6, 2018. Respondent represented that the medical records for Patient A were not and, to date, had not been transferred because his office had never received Patient A's medical records release. At his appearance, Respondent was accompanied by an office manager—not "Stephanie"—who represented that a new system had been implemented to track requests for medical records and subsequent delivery of the records to the requesting party. Respondent had been mailed notice of complaint 180165 on February 14, 2018, followed by Final Notice of complaint 180165 on

March 27, 2018.

7. With respect to Patients B and C, Respondent stated that the records were transferred on March 23, 2018 and that he did not know why the records were not received by the succeeding physician's office. Respondent stated that the records for both Patients—B and C—were sent again on September 18, 2018. Respondent also noted that the office manager, "Stephanie," referenced in complaint 180597, no longer works at NPPC.

8. The Investigative Committee noted the Board has received multiple, similar complaints from Respondent's patients in the past, to the effect that requested medical records are not received in a timely manner. The Investigative Committee concluded that Respondent did not have an adequate system in place prior to these complaints (180165 and 180597) to ensure the reliable transfer of medical records for his patients. Accordingly, the Investigative Committee concluded that Respondent violated R.I. Gen. Laws § 5-37-5.1(10), which defines "unprofessional conduct" as including "*[f]ailing to furnish details of a patient's medical record to succeeding physicians, healthcare facility, or other healthcare providers upon proper request*," and Section 1.5.12(B)(5) of the Rules and Regulations for Licensure and Discipline of Physicians (216-RICR-40-05-01), which provides, "*Requested records must be provided within thirty (30) days of the receipt of the written request or signed authorization for records*." Further, based on Respondent's violation of the above-referenced regulation, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24), which defines "unprofessional conduct" as including, "*[v]iolating any provision or provisions of [Chapter 5-37 of the R.I. Gen. Laws] or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board*."

9. The Board received complaint 180890, dated July 10, 2018, from Patient D (alias), an

NPPC patient, alleging unfair treatment by Respondent. Specifically, Patient D stated, "*I am filing an [sic] complaint against [Respondent] because I am not being treated fairly as a patient. I have been going there for over 10 years and can not get the things I need in order to maintain my health. My referrals for specialist are not being sent over so that I am able to set up appointments for example I have been trying to see an [sic] neurologist since May 2018 and still unable to set up an appointment. Every time I called the neurologist they state that the [sic] have not received the required documents from my provider which means I can not be seen*."

10. In his written response to the Board, Respondent stated that Patient D was referred to a neurologist on April 10, 2018 and that all pertinent information was faxed to CharterCare Neuro on April 16, 2018. Respondent stated, further, that when Patient D was seen, again, on May 17, and Patient D advised that she had not heard from the referred neurologist, Patient D was referred to a different neurologist on May 24, 2018.

11. Review of Patient D's medical record reveals no documentation of Patient D's referrals or that ongoing care would be coordinated for Patient D.

12. The Investigative Committee concluded that Respondent did not have office practices in place to ensure that Patient D would have timely access to specialty care; in this case, neurology. Accordingly, the Investigative Committee concluded that Respondent failed to meet the standard of care.

13. The Board received complaint 190654 from a nurse who was formerly employed by Respondent at CNEUC ("Complainant #1"). In her complaint, Complainant #1 alleges numerous health and safety concerns. Of particular note is that Complainant #1 was new to the practice and was not adequately oriented or trained to work there prior to being tasked with unsupervised practice. Additionally, Complainant #1 reported that Respondent was angry,

yelled, threw charts, and was intimidating and difficult to work with. In addition to her written complaint, Complainant #1 also appeared before the Investigative Committee.

14. Complainant #1 and Respondent agree that complainant worked at CNEUC for a period of three days. Complainant alleges that she was not adequately trained and oriented to work there and was unaware of office workflow and procedures, as well as the location of common office tools and manuals. Complainant #1 and Respondent agree that Complainant #1 was shown around CNEUC for a period of two days and, during that time, was shown some office policies.

15. Respondent appeared before the Investigative Committee on November 7, 2019, at which time he stated that Complainant #1 was trained, but acknowledged that CNEUC did not maintain a training file and did not verify the competency of new employees, including nurses, in various clinical or administrative tasks. Respondent stated the customary practice of CNEUC is to orient new nurses for two to three days and then to evaluate them after two weeks to determine how they were performing. The Investigative Committee observed that the training, as described by Respondent, was primarily passive and lacked verification of employee ability to perform common office and clinical duties. Relative to Complainant #1, Respondent recalled one instance, on day three of Complainant #1's employment, when Complainant #1 was incorrectly reconstituted ceftriaxone, which is an antibiotic commonly used in urgent care settings. Relative to that incident, Complainant #1 stated that she was unsure of whether she had properly reconstituted the drug; she admitted that she did not know how to perform the task, stating that it was not her area of expertise and that she had not been trained to do it. The drug, in this instance, was not administered, as the error was caught by Respondent. Complainant #1, after a verbal altercation with Respondent, left her position at CNEUC.

16. The Investigative Committee determined that Respondent, as the owner and medical director of CNEUC, is responsible for ensuring the competency of employed nurses, such as Complainant #1; that they are adequately trained and safe to see and interact with patients. The Investigative Committee determined that Respondent's permitting Complainant #1 to interact with patients independently, without adequate orientation and training, is below the standard of care.

17. Based on the foregoing, 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*."

18. The Board received complaint 180704 from the attorney for Patient E (alias), an NPUC patient ("Complainant #2), alleging that Respondent fraudulently accepted payment from a liability insurance carrier for treatment he did not render. The complaint alleged that Patient E "*is being required to reimburse the liability carrier for treatment she never received*."

19. An investigator for the Board ("Investigator") contacted Complainant #2's office at the direction of the Investigative Committee and obtained the following additional facts: (1) Patient E was in a motor vehicle accident on July 26, 2016; (2) Patient E, at the time of the accident, had Neighborhood Health Plan of Rhode Island ("NHPRI") health insurance; and (3) the other driver was at fault for the accident and was insured by Commerce Insurance Co., which insurer accepted liability and agreed to pay Patient E's claim for damages.

20. Patient E. was treated at NPUC on July 28, 2016. Patient E's bill for services rendered was $575. On Aug. 31, 2016, Complainant #2 advised NPUC's billing agent—NE Medical

Billing—to submit Patient E's bill to NHPRI and Medicare.

21. Patient E's legal action against the other driver settled in February of 2017. Complainant called NE Medical Billing and NPUC on numerous occasions to determine whether Patient E's bill for services rendered pursuant to the accident remained outstanding and, if so, for how much. In May of 2017, Complainant #2 was informed that Patient E's bill had been paid in full, as NPUC had accepted payment from USAA. Patient E had never been insured by USAA, however. The associated Explanation of Remittance ("EOR") shows that USAA's payment was in the name of an individual who, coincidentally, has the same name as Patient E, but is from Roswell, New Mexico.

22. On January 3, 2018, Complainant #2 requested that NPUC return to USAA the money erroneously paid toward Patient E's bill in order to prevent USAA from pursuing Patient E for the funds; NPUC refused. Thereafter, on January 10, 2018, Complainant #2 was advised by USAA that it had submitted to NPUC a request to NPUC for the erroneously paid funds. Subsequently, on March 28, 2018, Complainant #2 was advised by USAA that, despite having been informed that payment on Patient E's bill had been in error, NPUC had not returned the funds to USAA. When Patient E appeared at NPUC in person on May 9, 2018 to resolve the matter, NPUC advised Patient E that it would not speak with her unless she signed a lien for payment of $575.00.

23. The Investigative Committee concluded that Respondent lacked adequate systems in his office to ensure billing errors were properly identified and promptly resolved. Based on the foregoing, Respondent violated R.I. Gen. Laws § 5-37-5.1(16), which defines "unprofessional conduct" as including "*[g]ross and willful overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered*."

24. The Board received complaint 190616 from a former employee of Respondent, alleging that radiation badges were not appropriately monitored and replaced at NPUC.

25. Based on the allegations set forth in complaint 190616, the Investigative Committee requested that the Rhode Island Department of Health ("RIDOH") Radiation Control Program ("RCP") conduct an inspection of NPUC.

26. Pursuant to the inspection, the RCP inspector identified multiple violations, including Section 3.3(A) of the Rules and Regulations for the Registration of X-Ray Equipment Facilities and Radiation Physics Services (216-RICR-40-20-3), which provides in relevant part, "*All registrants shall prohibit any person from furnishing X-ray equipment servicing or radiation physics services . . . to their X-ray equipment facility until such person provides evidence that they are registered with the Agency as a provider of services*." The RCP inspector noted, "*Contrary to these requirements, as of June 28, 2019, [Respondent] had utilized a company that was not registered with the [RCP] to provide dosimetry services.*" The Inspector noted that this violation constitutes a Severity Level IV deficiency.

27. The RCP inspector also found violation of Section 2.6 of the Rules and Regulations for Notices, Instructions, and Reports to Workers; Inspections and Compliance Procedures (216-RICR-40-20-2), which incorporates by reference 10 C.F.R. 19.13, which requires registrants to retain records of individual dose monitoring for each year a worker was required to be monitored and report radiation exposure data to a monitored individual on at least an annual basis and upon termination. The RCP inspector noted, "*Contrary to this requirement, as of 28 June 2019, monthly and annual radiation exposure dose records were not available for review for the period between 2016 – 2018 and the registrant did not provide personnel who had terminated employment with their personal monitoring results*." The RCP inspector noted that this violation

constitutes a Severity Level IV deficiency.

28. The RCP inspector also found violation of Section 4.3.13(A)(2) of the Rules and Regulations for Diagnostic X-Rays and Associated Imaging Systems in the Healing Arts (216-RICR-40-20-4), which requires the registrant to maintain a user's manual for each X-ray system. The RCP inspector noted, "*Contrary to this requirement, as of 28 June 2019, a user manual for the Amrad Model E7239FX was not available for . . . review*." The RCP inspector noted that this violation constitutes a Severity Level IV deficiency.

29. The RCP inspector also found violation of Section 4.10.1(A) of the Rules and Regulations for Diagnostic X-Rays and Associated Imaging Systems in the Healing Arts (216-RICR-40-20-4), which requires that all registrants establish and maintain a quality assurance program which includes employee review and written acknowledgement of the registrant's policies and procedures on radiation protection. The RCP inspector noted, "*Contrary to this requirement, as of 28 June 2019, written acknowledgement by employees of the registrant's policies and procedures on radiation protection were not available for . . . review*." The RCP inspector noted that this violation constitutes a Severity Level V deficiency.

30. The Investigative Committee reviewed Respondent's response to these allegations and concluded that the above-referenced regulations had been violated and that Respondent was responsible for their violation. Accordingly, the Investigative Committee concluded that Respondent violated the above-referenced R.I. Gen. Laws § 5-37-5.1(24).

31. The Board received complaint 190645 from Blue Cross & Blue Shield of Rhode Island ("BCBSRI"), notifying the Board that Respondent "*has been found to be prescribing and treating family members outside of the emergency parameters defined in [BCBSRI] policies*."

32. Review of the PDMP revealed that, on multiple occasions, Respondent prescribed controlled substances to a member of his immediate family, to wit, on January 6, 2019, alprazolam, which is a benzodiazepine, .5mg tablets (10) and on December 4, and 28, 2018, codeine-guaifenesin, which is a cough syrup containing an opioid, 240 ml. At an appearance before the Investigative Committee on November 7, 2019, Respondent admitted that he wrote these prescriptions and that the patient was a member of his immediate family.

33. The Investigative Committee concluded that Respondent violated Section 1.5.9(C) of the Rules and Regulations for the Licensure and Discipline of Physicians (216-RICR-40-05-1), relative to "Physician Self-treatment or Treatment of Immediate Family Members," which provides, "*A physician is not authorized to prescribed a controlled substance to one self or an immediate family member under any circumstances*." Further, based on Respondent's violation of the regulation, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24).

34. Respondent failed to produce a medical record for the above-referenced immediate family member to whom he prescribed opioids. The Investigative Committee concluded, therefore, that a medical record did not exist for the above-referenced family, in violation of Section 1.5.12(E) of the Rules and Regulations for Licensure and Discipline of Physicians, which provides, in relevant part, "*Failure to have the medical record in a completed format will be deemed grounds for unprofessional conduct*."

35. Further, the Investigative Committee determined that if the medical record did not exist, then, to the extent that Respondent engaged in any patient education/informed consent relative to prescribing opioids to his immediate family member, as required by Section 4.4(D) of the Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of

Controlled Substances in Rhode Island (216-RICR-20-20-4), Respondent nevertheless violated Section 4.4(D), which requires that such education "*be documented in the medical record*."

36. The Investigative Committee concluded that Respondent violated the above-referenced regulations. Further, based on Respondent's violation of the regulations, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24).

37. The Investigative Committee reviewed an audit of the PDMP and verified that, contrary to the requirements of Section 4.4(E) of the Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island (216-RICR-20-20-4), which provides "*The Prescription Drug Monitoring Program (PDMP) shall be reviewed prior to starting any opioid*."

38. Respondent did not review the PDMP prior to prescribing to his family member the above-referenced opioid medications. Accordingly, the Investigative Committee concluded that Respondent violated the above-referenced regulation. Further, based on Respondent's violation of the regulation, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24).

39. The Board received complaint 190622 from Patient F (alias), an NPPC patient, expressing difficulty in obtaining his medical records from Respondent.

40. Respondent, during his November 7, 2019 appearance before the Investigative Committee, admitted that his office's usual and customary practice is to charge per page for the production of medical records, even when the request is from the patient. Respondent further admitted that he was unaware that, by law, any fee for the production of medical records to the patient must be "reasonable" and "cost-based," including only the cost of "labor for copying," "supplies for creating the paper copy or electronic media," "postage," and "preparing an

explanation or summary."

41. The Investigative Committee concluded that Respondent violated Section 1.5.12(B)(1) of the Rules and Regulations for the Licensure and Discipline of Physicians, relative to "Medical Records," which provides, "*Reimbursement to the physician for responding to a patient request for a copy of their medical record, regardless of format, shall be consistent with federal law specifically 45 C.F.R. § 164.524*."[2] Further, based on Respondent's violation of the regulations, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24).

42. The Board received complaint 201005 from a patient who, when seeking care at NPUC, noted that staff were not wearing masks and the people in the waiting room were not practicing physical distancing.

43. On July 16, 2020, RIDOH sent an inspector to investigate the complaint and inspect NPUC. The inspector was only able to conduct an abbreviated inspection, however, because the office manager and Respondent were angry, uncooperative, and threatening. The inspector chose to exit the site to de-escalate the situation.

44. The inspector reported the results of the abbreviated inspection to RIDOH, and an Immediate Compliance Order ("ICO") was issued July 17, 2020, which ICO required Respondent to close and correct various violations, set forth below.

45. Based on the observations of the inspector, the Board concluded that Respondent violated a number of provisions of the Safe Activities Regulations.

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[2] 45 C.F.R. § 164.524(c)(4) provides, "If the individual requests a copy of the protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of: (i) Labor for copying the protected health information requested by the individual, whether in paper or electronic form; (ii) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; (iii) Postage, when the individual has requested the copy, or the summary or explanation, be mailed; and (iv) Preparing an explanation or summary of the protected health information, if agreed to by the individual."

46. Respondent violated Section 7.4.1(A)(3) of the Safe Activities Regulations, which requires each covered entity to instruct any person entering an establishment to wear cloth face coverings except when physical distancing from others in the establishment is easily, continuously, and measurably maintained or an exception applies, and to deny access to any employee who refuses to wear a cloth face covering when required. The inspector observed five employees inside NPUC during the inspection. One of the five employees was not wearing a cloth face covering when the inspector arrived, despite the fact the that physical distancing was observed by the inspector to be impossible for any of the employees to maintain. Three of the five employees were wearing cloth face coverings, but improperly. Once the employees realized that the inspector was from RIDOH, they all properly put on their face coverings.

47. Respondent is in violation of Section 7.4.1(A)(1) of the Safe Activities Regulations, which requires every covered entity to develop and maintain a written plan for the safe operation of its establishment with regard to COVID-19 during the state of emergency and to make this plan available to RIDOH upon request. Although Respondent identified himself as the point of contact, it was apparent to the inspector that Respondent was unaware of the Safe Activities Regulations, COVID-19-related executive orders, and other rules, regulations, and guidance relative to the re-opening of Rhode Island, and was unaware of Respondent's obligations thereunder. Respondent admitted that it did not have the required plan and that Respondent was unaware of its obligations to develop and maintain the required plan.

48. Respondent violated Sections 7.4.1(A)(6) and (7) of the Safe Activities Regulations, which require each covered entity to ensure the performance of environmental cleaning of their establishments once per day, to clean commonly touched surfaces, such as shared workstations, elevator buttons, door handles, and railings in accordance with the Centers for Disease Control

("CDC") guidance, and to maintain records documenting such environmental cleaning. The inspector noted that, although it appeared that environmental cleaning was taking place, Respondent was unable to produce the required logs.

49. Respondent violated Section 7.4.1(A)(2) of the Safe Activities Regulations, which requires each covered entity to implement and ensure compliance with screening individuals entering its establishment(s) at any time for any reason. The inspector noted several patients in line, none of whom was screened by NPUC staff.

50. Respondent violated Section 7.4.1(A)(4) of the Safe Activities Regulations, which requires covered entities to ensure placement of posters or signs at entry to its establishments educating any individual at the establishment concerning entry screening, required social distancing, use of cloth face coverings. The inspector observed that required posters were absent from the entry to the establishment and concluded that, consistent with Respondent's lack of awareness relative to its obligations under the Safe Activities Regulations, Respondent failed to ensure the placement of required posters.

51. Respondent is in violation of Sections 7.3(A) and 7.4.1(A)(1)(a) of the Safe Activities Regulations, which require, respectively, all individuals in public or in an establishment to maintain physical distancing at all times, to the extent feasible, and covered entities to address physical distancing in their establishments. As stated above, the inspector observed employees not wearing cloth face coverings despite being unable to maintain physical distancing. The inspector also observed that the NPUC waiting room remained set up to accommodate the maximum number of occupants, with seats set up side by side, there being no evidence of precautions taken by Respondent to maintain physical distancing among patients in the waiting room. For example, employees were observed sitting side by side, and chairs were observed to

be too close to the window for patients. Although waiting patients were properly distanced from one another, such distancing was caused by the patients, not by staff.

52. Respondent appeared before the Investigative Committee on complaint 201005 on November 5, 2020.

53. Based on Respondent's violations of the Safe Activities Regulations, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24).

54. The Board received complaints 201737, 201755, 201756 and 201758 between December 8 and December 13, 2020. All four complaints were submitted anonymously.

55. Relative to Respondent and his practice, complaint 201737 states, "*Staff, particularly one of them is out right now due to COVID, in addition [Respondent] and his family all have COVID, yet he is working in the office today 12-8-2020*."

56. Relative to Respondent, complaint 201755—which was a telephone complaint—states, "*Caller states she went for an appointment and [Respondent] was yelling at his staff and throwing things around. The caller states she left because it was so tense.*"

57. Relative to Respondent, complaint 201756—which was also a telephone complaint—states, "*[Respondent] and two front office staff tested positive last Friday [December 4, 2020]. He came in that Friday. He went down to the Urgent Care. He does not wear an N95 mask. No one has quarantined. Dr. Farina tested himself and his staff for COVID.*"

58. Complaint 201758 was submitted to the Board on Sunday, December 13, 2020. Board staff was able to contact the complainant ("Complainant #3) that day to discuss the substance of the complaint. It was apparent to the Board staff that Complainant #3 is fearful of Respondent. The complaint states that "*[Respondent] developed symptoms of COVID on November 22. He had cough, fever etc. He continued to remain in the clinic. He tested a few days later and was*

positive [for COVID-19]. He still continued to be in the clinic. He knowingly saw patients and infected the office." The complaint further alleges that Respondent's personal medical record was altered to reflect "*that he was not symptomatic until days after the time that he actually was*." The complaint further alleges that Respondent "*continued to see patients while knowingly sick. He passed the virus to employees. I think this was the wrong thing to do. All of this can be shown by looking at his record and asking a few of the employees (including the doctors). Dr Farina is frightening. He has temper tantrums and rage attacks daily and yells at the top of his lungs. He fires people on the spot. There's something wrong with him. Now I know this even more because he put his interests ahead of his patients and employees.*" Speaking with Board staff, Complainant #3 stood behind the allegations in the complaint.

59. Pursuant to the Board's contact with Complainant #3, the Director issued subpoenas for three witnesses—Witnesses A, B, and C (aliases)—requesting their appearance before the Investigative Committee at the next available meeting, which was January 7, 2021. All three witnesses appeared. All three represented to the Investigative Committee their belief that if Respondent knew they were testifying against him they would suffer retribution.

60. Separately, Respondent also appeared before the Investigative Committee on January 7, 2021. That day, Respondent stated that on or about November 25, 2020 he had a sinus infection, for which he sought care at his urgent care. There, he was evaluated and treated by a physician. Respondent stated that he was prescribed Azithromycin and felt better within a few days. Respondent claimed that his symptoms were congestion and green nasal discharge. He specifically stated that he was not coughing and did not have a fever and that he was, otherwise, well. Respondent stated that he was not offered a COVID-19 test and, further, opined that testing for COVID-19 was not clinically indicated. Respondent further told the Investigative

Committee that, in the approximately nine days between November 25, 2020 and December 4, 2020, he recovered from the sinus infection and subsequently developed a new illness with fatigue and nausea and tested positive for COVID-19 on December 4, 2020. Respondent stated that, after testing positive, he isolated appropriately and wore an N-95 mask when in the office.

61. Witness A, who has direct knowledge of facts relevant to this matter, represented to the Investigative Committee that Respondent was, indeed, ill on November 25, 2020, on which date Respondent was evaluated and treated at his urgent care clinic. Witness A stated, however, that it was recommended that Respondent be tested for COVID-19, but Respondent declined. Witness A informed the Investigative Committee that Respondent went to work while symptomatic prior to testing positive for COVID-19 on December 4, 2020. Separately, Witness A informed the Investigative Committee that Respondent often yells at staff in front of patients and creates a work environment that is uncomfortable. Witness A is intimidated by and fearful of Respondent due to Respondent's behavior in the workplace.

62. Witness B, who has direct knowledge of facts relevant to this matter, told the Investigative Committee that Respondent was evaluated and treated at the urgent care on or about November 25, 2020 for symptoms consistent with COVID-19. Witness B, who, though an eye witness was not a treating health care provider, described Respondent as appearing ill at the time—ashen and diaphoretic. Witness B also stated that Respondent declined a COVID-19 test and came to work symptomatic, where he met with staff and saw patients. Witness B stated that though Respondent wore an N-95 mask, it did not cover his nares. Separately, Witness B also stated that he is fearful of Respondent and that Respondent often yells at staff in front of patients and creates a hostile workplace.

63. Witness C (alias), who has direct knowledge of facts relevant to this matter, told the

Investigative Committee that he knew of the illness Respondent acknowledges experiencing on or about November 25, 2020, and that Respondent ultimately tested positive for COVID-19 on December 4, 2020. Witness C told the Investigative Committee that Respondent was in the office while symptomatic and that when he wore an N-95 mask it did not cover his nose. Additionally, Witness C told the Investigative Committee that Respondent met with staff during the period when he should have been isolating. Separately, Witness C reported that Respondent frequently yells at staff in front of patients and creates a hostile work environment.

64. The Investigative Committee evaluated the four complaints and the statements of Witnesses A-C and found that Witnesses A-C were credible, and corroborated the substance of the four complaints. The Investigative Committee found that Respondent, on the other hand, was not credible.

65. The Investigative Committee determined that Respondent's overall disruptive behavior represents an immediate danger to the public. The Investigative Committee also determined Respondent acted recklessly in electing not to receive a COVID-19 test and failing to isolate during the illness for which he was treated on November 25, 2020 and especially after testing positive for COVID-19 on December 4, 2020. Respondent had easy access to testing for COVID-19 in his own office and should have been tested at that visit, but Respondent refused. Respondent's decision to work in the office during the isolation period after the December 4, 2020 positive test put the health and well-being of patients, employees, and others at risk. The Investigative Committee unanimously determined that Respondent should be summarily suspended and requested Board staff recommend this action as quickly as possible to the Director.

66. The Investigative Committee determined the behavior described in complaints 201737,

201755, 201756, and 201758 was deliberate and that Respondent violated R.I. Gen. Laws § 5-37.5.1(19), which defines unprofessional conduct as including, "*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.*"

ORDER

After considering the above findings, the Director has determined evidence in her possession indicates that Respondent's continuation in practice would constitute an immediate danger to the public and that the public health, safety and welfare imperatively requires emergency action. It is accordingly ordered that:

1. Respondent is hereby suspended from practicing medicine until further Order of the Department of Health or Board of Medical Licensure and Discipline;

2. Respondent is ordered to report to the Rhode Island Medical Society Physicians Health Program for evaluation and follow their recommendations.

Respondent is entitled to an administrative hearing on this suspension in accordance with Rhode Island General Laws §§ 42-35-14(c), 5-37-8, and 21-28-3.05.

Signed this _____ day of January, 2021,

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

3 Capitol Hill, Room 401
Providence, RI 02908

CERTIFICATION

I hereby certify that on this _____ day of January, 2021, this Summary Suspension was delivered by email and certified mail to Respondent, via his attorneys, Dennis Grieco, Esq. and Timothy Frawley, Esq., as follows:

Dennis Grieco, Esq.
70 Jefferson Blvd
Warwick, RI 02888
dgrieco@grieco-law.com

Timothy Frawley, Esq.
495 Hope St, Suite 3
Bristol, RI 02809
timothy.frawley@tfrawleylaw.com

/s/ James McDonald_____
James V. McDonald, MD, MPH