

**STATE OF RHODE ISLAND  
DEPARTMENT OF HEALTH  
BOARD OF MEDICAL LICENSURE AND  
DISCIPLINE**

**In the matter of:**

**WILLIAM T. CREIGHTON, M.D.            C04-726**

**License #: MD 8301**

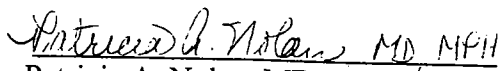
**SUMMARY SUSPENSION**

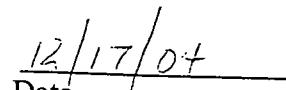
1. Respondent is a physician licensed to practice in Rhode Island. He is a graduate of Creighton University Medical School.
2. Respondent's medical license was reinstated in August of 2003 following a suspension beginning in 1999 for engaging in sexual relationships with patients and prescribing narcotic drugs to them inappropriately.
3. Upon Reinstatement, Respondent's license was restricted to working under the supervision of another physician in a group or institutional setting. He has been practicing under the supervision of Fred Vohr, MD and has been seeing patients primarily in nursing homes.
4. Respondent saw an 85 year-old male patient at the Harborside Nursing Home after a prior hospital admission for pneumonia. The patient had been given a gastric tube within the previous nine days but the patient had pulled it out.
5. Respondent saw the patient at bedside and had reinserted the gastric tube.

6. Respondent neither ordered appropriate tests to insure proper placement of the tube nor documented in the chart that he had replaced the tube.
7. The gastric tube subsequently was used by nursing staff for medication administration and nutrition.
8. The patient's condition worsened over a period of hours, he developed abdominal distention and he was sent to the hospital where he was diagnosed with chemical peritonitis from an extravasion of enteral feedings around the percutaneous endoscopic gastrostomy feeding tube.
9. The patient expired at the hospital due to complications of peritonitis.
10. The Respondent's failure to take appropriate steps to insure that an immature feeding tube had been replaced appropriately and failure to document the reinsertion of the feeding tube violated the appropriate standard of patient care.
11. Respondent violated Rhode Island General Laws § 5-37-5.1 for reinserting the percutaneous endoscopic gastrostomy feeding tube at the bedside less than two weeks after initial placement and failing to confirm tube placement by appropriate means and for failure to document the reinsertion of the tube in the medical record.

### ORDER

Respondent's license to practice medicine is hereby Suspended pursuant to R.I.G.L. § 5-37-8 after finding that the Respondent's continuation in practice would constitute and immediate danger to the public. Respondent is entitled to a hearing within 10 days of the date of this order.

  
Patricia A. Nolan, MD.MPH  
Director of Health

  
Date