STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH PROFESSIONS
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

A. ALBERTO HODARI, M.D.
_____/ Complaint No. 43-06-102963

ADMINISTRATIVE COMPLAINT

Attorney General Michael A. Cox, through Assistant Attorney General Merry A. Rosenberg, on behalf of the Department of Community Health, Bureau of Health Professions, (Complainant), files this Administrative Complaint against A. Alberto Hodari, M.D., (Respondent), alleging upon information and belief as follows:

1. The Board of Medicine, (Board), an administrative agency established by the Public Health Code, (Code), 1978 PA 368, as amended; MCL 333.1101 et seq, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee (DSC).

2. At all times relative to this Administrative Complaint, Respondent was licensed by this Board and was Board certified in obstetrics/gynecology.

3. Section 16221(a) of the Code provides the DSC with authority to take disciplinary action against licensees for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, his ability to safely and skillfully practice medicine.

4. Section 16221(b)(i) of the Code provides the DSC with authority to take disciplinary action against Respondent for incompetence, defined at section 16106(1) to mean "[A] departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession whether or not actual injury to an individual occurs".

5. Section 16221(b)(vi) of the Code authorizes the DSC to take disciplinary action against Respondent for a lack of good moral character, defined at section 1 of 1974 PA 381, as amended; MCL 338.41 et seq, as the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner.

6. Section 16226 of the Code authorizes the DSC to impose specific sanctions on a licensee after finding the existence of one or more of the grounds for action listed in section 16221.

7. Patient R.J., (initials will be used to protect patient confidentiality), a 32 year old female, G4-P1-AB2, presented to Womencare of Southfield on September 17, 2003, to undergo a voluntary termination of a five-week pregnancy. Respondent was the owner of Womencare of Southfield. He was not present in the facility on September 17, 2003.

8. Cathy Lichtig, R.N., performed an ultrasound of R.J.'s abdomen even though there was no physician order for the study. She interpreted the study as showing a five week pregnancy and signed Respondent's name, even though he was not present at the facility

September 17, 2003. Obstetrician-gynecologist Milton Nathanson, M.D., initialed the ultrasound, confirming Ms. Lichtig's interpretation.[1]

9. Barry Thompson, C.R.N.A., was the anesthetist assigned to perform the anesthesia services for the termination. The termination procedure was performed by Milton Nathanson, M.D., an obstetrician-gynecologist employed by Respondent.

10. R.J. received 200mg Diprivan, Fentanyl 2mg, Gylcopyrrolate .2mg, and Droperidol during the procedure, which lasted ten minutes, from 09:55 to 10:05.

11. R.J. was then admitted to the recovery room. Cathy Litchtig, R.N., was assigned to work in the recovery room shortly after R.J. arrived. At the time of this assignment, five or six other patients were in the recovery room under Ms. Lichtig's care. Although the Womencare protocol provided for more than one person to be in the recovery room when patients were present, Ms. Lichtig was alone at times during the morning of September 17, 2003.

12. The recovery room equipment at Womencare included a stethoscope, oxygen bag with mask and a digital blood pressure cuff. The room was *not* equipped with an EKG monitor, oxygen, pulse oximeter, automatic blood pressure/pulse monitor with an alarm, defibrillator or other resuscitation equipment available.

13. Nurse Lichtig manually took and recorded R.J.'s blood pressure and heart rate soon after R.J.'s admission to the recovery room at 10:05 and ten minutes later, at 10:15. Ms.

[1] The termination procedure was performed by Milton Nathanson, M.D., an obstetrician-gynecologist employed by Respondent.

Lichtig did not monitor R.J. continuously; she took R.J.s blood pressures manually every 10-15 minutes. At 10:05, R.J's blood pressure was 116/72 and her heart rate was 82; at 10:15, the blood pressure was 108/56 and her pulse was 88.[2] Ms. Lichtig subsequently authored a note that added that R.J.'s respirations were easy and unlabored at 10:05 and 10:15.

14. Nurse Lichtig could not rouse R.J. at 10:30. However, she had a pulse and her respirations were easy and unlabored. For approximately the next ten minutes, Nurse Lichtig unsuccessfully tried to awaken R.J. At approximately 10:40, she could not get a pulse. She immediately informed Mr. Thompson, who was wheeling another patient into the recovery room at the time.

15. Mr. Thompson and Nurse Lichtig returned R.J. to the operating room and began CPR. EMS was not contacted until 11:00 a.m.; they arrived at Womencare at 11:05.

16. At 11:24 a.m., EMS transported R.J. to Providence Hospital, where they arrived at 11:30; CPR was continued and a pulse was obtained. R.J. was maintained on life support until a determination of brain death was made. Life support was withdrawn and R.J. died on September 18, 2003.

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[2] According to the Womencare protocol, the recovery room nurse was to record vital signs upon the patient's admission to the recovery room, at fifteen minutes, and then at discharge for those patients who had received general anesthesia for their termination procedure. This meant there was no requirement that vital signs be taken and recorded between 15 minutes and the patient's discharge, which usually occurred about an hour after admission to the recovery room. he protocol allowed for the recovery room nurse to discharge the patient. There was no provision that the patient be seen by a physician once she was transferred tot he recovery room.

17. An autopsy was performed; the cause of death was identified as anoxic encephalopathy due to cardiac arrest following elective abortion under general anesthesia.

COUNT I

18. Respondent's conduct as set forth above constitutes negligence, in violation of section 16221(a) of the Code.

COUNT II

19. Respondent's conduct as set forth above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT III

20. Respondent's conduct as set forth above constitutes a lack of good moral character, in violation of section 16221(b)(vi) of the Code.

WHEREFORE, Complainant requests that a hearing be scheduled pursuant to the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*, the Public Health Code, and rules promulgated thereunder, to determine whether disciplinary action should be taken against Respondent for the reasons set forth above.

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(7) of the Public Health Code, Respondent has 30 days from receipt of this Complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Health Services, Department of Community Health, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned Assistant Attorney General. Further, pursuant to section 16231(8), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the Complaint and shall result in transmittal of the Complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully submitted,

MICHAEL A. COX
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Dated: August 6, 2007

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