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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL ANGELO BASCO, M.D.** 1115 4th Street SE Washington, DC 20003 Physician's and Surgeon's Certificate No. G88898 Respondent.	Case No. 16-2013-232621 **ACCUSATION**

The Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Medical Board of California, Department of Consumer Affairs.

2. On March 16, 2011, Physician's and Surgeon's Certificate No. G88898 was issued by the Medical Board of California to Michael Angelo Basco, M.D. (Respondent). Said certificate is renewed and current with an expiration date of October 31, 2014, and is SUSPENDED pursuant to an Order issued on June 20, 2013 under Business and Professions Code Section 2310.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California[1], (the Board) under the authority of the following sections of the California Business and Professions Code (Code) and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state or any agency of the federal government upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
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> "(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Federal Government)

4. On May 29, 2013, the Maryland State Board of Physicians issued an Order for Summary Suspension of License to Practice Medicine (Order for Summary Suspension.) The Order for Summary Suspension was based on investigative findings that Respondent, an

[1] The terms "Board" and "Division" or "Division of Medical Quality" mean the Medical Board of California.

obstetrician/gynecologist, was affiliated with a practice that provided abortion services at several offices in Maryland. The facilities were closed and their licenses suspended based on significant and serious violations of Maryland's surgical abortion facility regulations. It was alleged that Respondent practiced in the facilities and performed abortions during a time when the facilities in question violated numerous provisions of the governing regulations, which could have resulted in serious or life-threatening harm or death to patients, and that he continued to practice at the facilities when no satisfactory plans of correction had been submitted to address the deficiencies. It was also alleged that Respondent practiced in an environment in which unlicensed/untrained office staff were allowed to perform physical examinations including ultrasounds, evaluated fetal gestational age, and provide medications to patients to promote abortions, and to administer medication to patients who had not been evaluated by a physician even if no physician was available on site. Based on these findings, Respondent's Maryland license was summarily suspended. A copy of the Order for Summary Suspension of License to Practice Medicine issued by the Maryland State Board of Physicians is attached as Exhibit A.

5. Respondent's conduct and the action of the Maryland State Board of Physicians as set forth in paragraph 4, above, constitute unprofessional conduct within the meaning of section 2305 and conduct subject to discipline within the meaning of section 141(a).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G88898 issued to respondent Michael Angelo Basco, M.D.;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants;

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3. Ordering Respondent, if placed on probation, to pay the costs of probation monitoring; and

4. Taking such other and further action as the Board deems necessary and proper.

DATED: August 1, 2013

KIMBERLY KIRCHMEYER
Interim Executive Officer
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

IN THE MATTER OF	*	**BEFORE THE**
MICHAEL A. BASCO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D72935	*	**Case Numbers: 2013-0723 and 2013-0853**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **MICHAEL A. BASCO, M.D.** (the "Respondent") (D.O.B., 10/05/1959), License Number D72935, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2009 Repl. Vol. and 2012 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

medicine in Maryland on August 17, 2011, under License Number D72935. The Respondent's license is scheduled for renewal on September 30, 2014

2. The Respondent is board-certified in obstetrics and gynecology.

3. At all times relevant hereto, the Respondent was affiliated with Associates in OB/GYN Care, LLC ("OB/GYN Care"), a practice that provides abortion services at offices located in Baltimore, Frederick, Cheverly and Silver Spring.

4. The Board initiated an investigation of the Respondent after reviewing recent actions the Maryland Office of Health Care Quality ("OHCQ")[2] took against OB/GYN Care. OHCQ summarily suspended the licenses of three of OB/GYN Care's offices on or about March 5, 2013, and suspended the licenses of all four of its offices on May 9, 2013, for violations of the State's surgical abortion facility regulations. *See* Code Md. Regs. ("COMAR") tit. 10, §§ 12.01.01 *et seq.*

5. OHCQ determined that OB/GYN Care's continuing violations of the State's surgical abortion facility regulations placed patients at risk of serious harm or death. OHCQ ordered that OB/GYN Care immediately cease providing surgical abortions after its investigation determined that the public health, safety or welfare imperatively required emergency action.

6. The Respondent provided abortion services at OB/GYN Care's offices during the time of OHCQ's survey in February 2013 and was also the sole physician on duty during an incident that occurred at the Baltimore office on May 4, 2013, when the OHCQ found that the facility "was not equipped to complete a procedure safely . . .

[2] OHCQ licenses and certifies state health care facilities and monitors the quality of care in those facilities. OHCQ monitors state health care facilities under its jurisdiction for compliance with all applicable state and federal regulations.

failed to implement a safe discharge plan for the patient . . . [which] . . . could have resulted in serious or life-threatening harm or death to the patient."

7. After reviewing these investigative findings, the Board issues this Order for Summary Suspension pursuant to Md. State Gov't Code Ann. § 10-226(c)(2). The Board concludes that the Respondent's actions constitute a substantial likelihood of risk of serious harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license to practice medicine.

OHCQ Investigation

8. OHCQ initially inspected OB/GYN Care's surgical abortion facilities in February 2013, during which time it found that OB/GYN Care committed numerous violations of the State's surgical abortion facility regulations. After considering these findings, the Secretary of the Department of Health and Mental Hygiene summarily suspended the licenses of OB/GYN Care's Baltimore, Cheverly and Silver Spring offices, concluding that there was a threat to the public health and safety.

9. OHCQ found that OB/GYN Care's Cheverly facility was in violation of COMAR 10.12.01.09 because (a) the pads of its Automated External Defibrillator ("AED") expired in 2008; (b) the clinical nurse on site did not know how to use the AED and suction machine; (c) the District Manager admitted to the surveyor that the nurses had not been trained on the use of the AED and suction machine; and (d) the suction machine did not work because an adapter was missing.

10. OHCQ found that OB/GYN Care's Baltimore and Silver Spring locations violated COMAR 10.12.01.07A and B by failing to perform surgical abortion services in a safe manner and by failing to develop appropriate post-anesthesia procedures and

protocols. During the survey, OHCQ inspectors evaluated the Respondent's performance of an abortion on February 26, 2013, at the Silver Spring office. OHCQ investigators found that the Respondent left a patient unattended for a period of time after he administered conscious sedation to her and performed an abortion, which constituted a violation of COMAR 10.12.01.07B(4).

11. The Secretary subsequently lifted the suspensions of the clinics' licenses pending OB/GYN Care's submission of acceptable written correction plans. To date, however, OB/GYN Care has not filed acceptable plans of correction for all of the deficiencies at each site. In addition, OB/GYN Care has not responded to repeated telephone calls and emails from OHCQ and is thus not in compliance with the regulations for abortion facilities in this State.

12. OHCQ then received an anonymous complaint, dated May 7, 2013, regarding treatment a patient (the "Patient") received at OB/GYN Care's Baltimore office on May 4, 2013, when the Respondent was scheduled to perform surgical abortions.

13. The complaint stated that the Patient presented to OB/GYN Care's Baltimore office on May 4, 2013, for a scheduled appointment for an abortion. At the time, no physician was on site.

14. An OB/GYN Care employee asked the Patient to complete the initial paperwork. The same employee, who holds no health care license or certification, then performed an ultrasound on the Patient that revealed multiple gestations. The employee had no training or demonstrated competency in performing ultrasounds. The employee then asked the Patient to sign a form giving consent for a surgical abortion and for the administration of misoprostol, a medication that is used to induce abortions.

The employee administered the misoprostol to the Patient when no physician was present in the facility and before any physician or licensed health care professional had any contact with the Patient.

15. The Respondent then arrived at the office and determined that the Patient, due to multiple gestations, had a 22-week sized uterus. The Respondent declined to complete a surgical abortion, stating that the facility was not equipped to perform the procedure safely.

16. The Respondent verbally offered the Patient three options: (a) The Patient could travel in two days to OB/GYN Care's Frederick office for the administration of laminaria, a type of seaweed that is used to dilate the cervix, and additional misoprostol, with follow-up the following day in OB/GYN Care's Baltimore facility for a dilatation and curettage ("D & C") and follow-up the day after that in OB/GYN Care's Cheverly or Silver Spring office for a second D & C, if needed; (b) An OB/GYN Care employee could transport the Patient to a site in New Jersey where a surgical abortion could be performed with the Patient under general anesthesia; or (c) The Respondent could attempt to identify a local hospital that could complete a surgical abortion procedure.

17. The Patient reportedly chose the first option and left the facility. OB/GYN Care staff provided no written discharge instructions. The Patient's medical record did not accurately describe what occurred and what was discussed with the Patient during the encounter. Later that day, the Patient presented to another facility that was not associated with OB/GYN Care, where the staff completed a surgical abortion procedure with no reported complications.

18. The Respondent practiced in an environment in which unlicensed/untrained office staff were allowed to perform physical examinations including ultrasounds, evaluated fetal gestational age, and provided medications to patients to promote abortions. OB/GYN Care staff admitted to OHCQ surveyors that OB/GYN Care's standard protocol was to administer misoprostol to all patients at 11 weeks' gestation or beyond, even if the patient had not been evaluated by a physician, and even if no physician was available on site. OHCQ investigators interviewed the Respondent, who stated all OB/GYN Care offices follow this standard protocol.

19. OHCQ investigation determined that OB/GYN Care initiated a surgical abortion in a facility that was not equipped to complete the procedure safely. In addition, OB/GYN Care failed to implement a safe discharge plan for the Patient. These deficiencies constitute violations of COMAR 10.12.01.07A and 10.12.01.01A, which could have resulted in serious or life-threatening harm or death to the Patient.

20. On May 8, 2013, OHCQ inspectors went to OB/GYN Care's Baltimore office during the facility's reported hours of operation to investigate the complaint. The office was closed at that time in violation of COMAR 10.12.01.04A(2).

21. The Respondent provided abortion services at OB/GYN Care during which time its offices violated numerous provisions of the State's surgical abortion facility regulations, which could have resulted in serious or life-threatening harm of death to patients. To date, OB/GYN Care has not submitted satisfactory plans of correction to address these deficiencies. Thus, the Respondent continued to provide abortion services at offices that are not in compliance with the State's surgical abortion facility regulations.

22. In addition, the Respondent practiced medicine at OB/GYN Care with unauthorized persons or aided unauthorized persons in the practice of medicine there. The Respondent provided abortion services in offices in which unlicensed/untrained individuals performed ultrasounds, dispensed medications that can promote labor/abortions, and independently initiated treatment in violation of COMAR 10.32.12.04.

23. Based on these facts, the Board concludes that the Respondent constitutes an imminent threat to the public, which imperatively requires the suspension of his license.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2009 Repl. Vol. and 2012 Supp.).

ORDER

It is, by the affirmative vote of a majority of the quorum of the Board considering this case:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann. §10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that a post-deprivation hearing in accordance with Code of Maryland Regulations tit. 10, § 32.02.05.B(7), C and E on the Summary Suspension has been scheduled for **Wednesday, June 12, 2013 at 9:00 a.m.**, at the Maryland State Board of

Physicians, 4201 Patterson Avenue, Room 108, Baltimore, Maryland 21215-0095; and it is further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, request an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an administrative law judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's investigator the following items:

(1) his original Maryland License D72935;

(2) his current renewal certificate;

(3) DEA Certificate of Registration, # BB1794797 (exp. 07/31/13);

(4) Maryland Controlled Dangerous Substance Registration, # M76383 (exp. 11/30/13);

(5) All controlled dangerous substances in his possession and/or practice;

(6) All Medical Assistance prescription forms;

(7) All prescription forms and pads in his possession and/or practice; and

(8) Any and all prescription pads on which his name and DEA number are imprinted.

AND IT IS FURTHER ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol. and 2012 Supp.); and it is further

ORDERED that during the period of **SUMMARY SUSPENSION**, in accordance with the provisions of Title 4, subtitle 3 of the Health-General Article, the Respondent shall have a continuing duty, on proper request, to provide the details of a patient's medical record to the patient, another physician or hospital; and it is further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. and 2012 Supp.).

May 29, 2013
Date

Andrea Mathias, M.D., MPH
Board Chair
Maryland State Board of Physicians

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 6/11/13 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

DEPUTY DIRECTOR
MARYLAND BOARD OF PHYSICIANS