STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
BOARD OF MEDICINE

In the Matter of the
Application for Relicensure as a
Medical Doctor of

ABRAHAM ALBERTO HODARI, M.D.
License Number: 43-01-032422 File Number: 43-13-130412

NOTICE OF INTENT TO DENY
APPLICATION FOR RELICENSURE

The Michigan Board of Medicine, hereafter Board, by its authorized representative, Carole H. Engle, Director, Bureau of Health Care Services, hereafter Bureau, provides notice of its intent to deny the relicensure application of Abraham A. Hodari, M.D., hereafter Applicant, for the following reasons:

1. "Good moral character" is defined at Section 1 of 1974 PA 38, 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.

2. On or about on July 10, 2013, Applicant filed with the Board an application for relicensure as a medical doctor. On the application, Applicant answered "yes" to the following questions:

> Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?
>
> Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or

currently have disciplinary action pending against you?

3. Applicant's Application for Relicensure instructed him to "Submit a detailed explanation for any YES answer you check on a separate sheet of paper."

4. Applicant failed to submit any explanation for his "yes" answers, so the Bureau sent Applicant a letter requesting explanations.

5. On or about on August 5, 2013, the Bureau received a letter from Applicant which stated only, "After receiving your letter, this is the response. I have not held a medical license in any other state. I have attached a letter stating the last 5 malpractice settlement cases. I hope this helps! Thank you." The letter attached to Applicant's letter was from his attorney and listed five cases "where Dr. Hodari was the named defendant...." These letters failed to provide any detail regarding the nature or outcome of the cases disclosed by Applicant. Further, Applicant's explanation appears to be evasive because it disclosed only Applicant's "last 5 malpractice settlement cases" and did not offer a detailed explanation for any malpractice settlements, awards or judgments totaling $200,000 or more *in any five year period.* A copy of Applicant's letter and the letter from Applicant's attorney is attached as Exhibit A.

6. Applicant submitted no explanation for his "yes" answer to the question "Have you ever had a federal or state health professional license

revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?"

7. A review of Bureau records revealed that Applicant's license was disciplined on March 18, 2009 pursuant to a Consent Order of the Board's Disciplinary Subcommittee. Applicant was ordered to pay a fine in the amount of $10,000.00 for a violation of section 16221(a) of the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 et seq. The disciplinary action settled an Administrative Complaint (Complaint), which alleged Applicant's negligence regarding a 32-year-old patient that died after being treated at Womancare of Southfield, a facility owned by Applicant. A copy of Applicant's disciplinary documents is attached as Exhibit B.

8. Bureau records revealed that Applicant's license expired on January 31, 2013.

It is the intention of the Board to deny Applicant's application for relicensure to practice medicine in the state of Michigan for the reasons that:

a. Applicant's failure to provide detailed explanations for his "yes" responses on his Application for Relicensure, as set forth above, evidences a lack of good moral character, in violation of section 16221(b)(vi) of the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 et seq.

b. Applicant's malpractice settlements, awards, or judgments evidence that Applicant may not have the specific education or experience to promote safe and competent practice and a failure to meet one or more of the requirements for licensure under section 16174 of the Public Health Code,

supra, in violation of section 16221(l) of the Public Health Code, supra.

c. Applicant's failure to provide detailed explanations for his "yes" responses on his Application for Relicensure, as set forth above, evidences a lack of good moral character and a failure to meet one or more of the requirements for licensure under section 16174 of the Public Health Code, supra, in violation of section 16221(l) of the Public Health Code, supra.

In accordance with 1996 AACS, R 338.1624(3), Applicant bears the burden of proving, by a preponderance of the evidence, that Applicant meets the requirements for licensure set forth in section 16174 of the Public Health Code, supra.

Upon written request, Applicant shall be given an opportunity for a hearing, at which testimony and evidence may be presented on the Board's intent to deny Applicant's application for relicensure, provided that WITHIN 20 DAYS FROM THE DATE APPLICANT RECEIVES THIS NOTICE, Applicant files a written demand for hearing addressed to the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services, P. O. Box 30670, Lansing, MI 48909.

CONTINUED ON NEXT PAGE

If Applicant fails to request a hearing as indicated above, the within Notice of Intent to Deny Application for Relicensure shall be deemed the FINAL ORDER of the Board DENYING Applicant's application for relicensure to practice medicine in the state of Michigan.

MICHIGAN BOARD OF MEDICINE

Dated: 2-20-14

Carole H. Engle, Director
Bureau of Health Care Services

This is the last page of a Notice of Intent to Deny Application for Relicensure in the matter of Abraham A. Hodari, M.D., File Number 43-13-130412, before the Michigan Board of Medicine, consisting of five pages, this page included.

FMP

Dr. Alberto Hodari
27634 Five Mile Rd
Livonia, MI 48154

August 1, 2013

Michigan Board of Medicine
PO Box 30670
Lansing, MI 48909

To Whom It May Concern:

After receiving your letter, this is the response.

I have not held a medical license in any other state. I have attached a letter stating the last 5 malpractice settlement cases.

I hope this helps! Thank you.

Alberto Hodari MD

SIEMION HUCKABAY
ATTORNEYS AND COUNSELORS AT LAW
PROFESSIONAL CORPORATION

ONE TOWNE SQUARE
SUITE 1400
P.O. BOX 5068
SOUTHFIELD, MICHIGAN
48086-5068
PHONE (248) 357-1400
FAX (248) 357-3343
WEBSITE www.siemion-huckabay.com

July 30, 2013

TO WHOM IT MAY CONCERN:

We have gone through our records and the following are the last five cases where Dr. Hodari was a named defendant, although in some cases he had no personal involvement with the patient.

Very truly yours,

Robert P. Siemion

ROBERT P. SIEMION
Direct Dial: (248) 213-2010
rsiemion@siemion-huckabay.com

RPS:ljp

1. [redacted] v **Alberto Hodari, M.D. and Womancare of Southfield, P.C.**
Oakland County Circuit Court Case No. 10-107319-NH

2. [redacted] v **Alberto Hodari, M.D., Womancare of Southfield, P.C., et al.**
Oakland County Circuit Court Case No. 10-113534-NH

3. [redacted] v **Alberto Hodari, M.D. and Womancare of Southfield, P.C.**
Oakland County Circuit Court Case No. 07-084731-NH

4. [redacted] v **Alberto Hodari, M.D., Womancare of Southfield, P.C., et al.**
Oakland County Circuit Court Case No. 06-073847-NO

5. [redacted] v **Alberto Hodari, M.D., Womancare of Southfield, P.C., et al.**
Oakland County Circuit Court Case No. 05-063877-NM

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.
License No. 43-01-032422

Complaint No. 43-06-102963

/

CONSENT ORDER

An Administrative Complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on August 6, 2007, charging A. Alberto Hodari, M.D. (Respondent) with having violated sections 16221(a), (b)(i), and (b)(vi) of the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq.*

The parties have stipulated that the Disciplinary Subcommittee may enter this Consent Order. The Disciplinary Subcommittee has reviewed the Stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding Complaint. Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the Complaint are true and that Respondent has violated section 16221(a) of the Public Health Code.

Accordingly, for this violation, IT IS ORDERED:

Respondent is FINED $10,000.00 to be paid by check, money order or cashier's check made payable to the State of Michigan (with Complaint number 43-06-102963 clearly indicated

on the check or money order) within 30 days from the effective date of this Order. The timely payment of the fine shall be Respondent's responsibility.

Counts II and III of the Complaint, alleging a violation of Code sections 16221(b)(i) and (b)(vi), are DISMISSED.

Respondent shall mail the fine required by the terms of this Order to Sanction Monitoring, Bureau of Health Professions, Department of Community Health, P.O. Box 30185, Lansing, Michigan 48909.

If Respondent violates any term or condition set forth in this Order, Respondent will be in violation of 1996 AACS, R 338.1632, and section 16221(h) of the Public Health Code.

This Order shall be effective on the date signed by the Chairperson of the Disciplinary Subcommittee or the Disciplinary Subcommittee's authorized representative, as set forth below.

Signed on 3/18, 2009.

MICHIGAN BOARD OF MEDICINE

By _____
Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate as follows:

1. Respondent does not contest the allegations of fact and law in the Complaint. Respondent understands that by pleading no contest, he does not admit the truth of the allegations, but agrees that the Disciplinary Subcommittee may treat the allegations as true for resolution of the Complaint and may enter an Order treating the allegations as true and that they constitute a violation of section 16221(a) of the Code.

2. Respondent understands and intends that, by signing this Stipulation, he is waiving the right under the Public Health Code, rules promulgated under the Public Health Code, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended, MCL 24.201 *et seq*, to require the Department to prove the charges set forth in the Complaint by presentation of evidence and legal authority, and to present a defense to the charges before the Disciplinary Subcommittee or its authorized representative. Should the Disciplinary Subcommittee reject the proposed Consent Order, the parties reserve the right to proceed to hearing.

3. The Disciplinary Subcommittee may enter the above Consent Order, supported by Board conferee George Shade, M.D. Dr. Shade or an Assistant Attorney General from the Licensing and Regulation Division may discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

4. Dr. Shade and the parties considered the following factors in reaching this agreement:

A. Respondent has cooperated fully in the resolution of this Administrative Complaint and is remorseful for the events leading to it.

B. Board certified anesthesiologist, Marc Wittenberg, M.D., reviewed the practice setting at each of Respondent's Womencare Clinics where anesthesia is provided (Lansing, Lathrup Village, and Sterling Heights), to ensure that the anesthesia services provided at each site conform with the standard of care. To accomplish this, Dr. Wittenberg performed on-site inspections at each of the three locations and reviewed random charts at each site to evaluate the following:

1. That each of the sites was appropriately equipped with all necessary equipment to anesthetize and resuscitate patients both in the operating room and the Post Anesthesia Care Unit (PACU);

2. That the anesthesia record showed that appropriate anesthetic agents in appropriate amounts were utilized;

3. That the patients were appropriately monitored before and during their transfer from the operating room to the PACU;

4. That the patients were appropriately monitored by anesthesia personnel and registered nurses in the PACU;

5. That the ratio of nurses to patients in the PACU conformed with minimal standards of acceptable medical practice, *to-wit*, two patients to a registered nurse;

6. That the decision to discharge patients from the PACU was made by the surgeon performing the procedure and according to acceptable standards of practice.

(See attached letter verifying this review from Respondent's attorney to Assistant Attorney General Merry Rosenberg dated February 26, 2009.)

By signing this Stipulation, the parties confirm that they have read, understand and agree with the terms of the Consent Order.

AGREED TO BY:

Merry A. Rosenberg (P32120)
Assistant Attorney General
Attorney for Complainant
Dated: 3/9/09

AGREED TO BY:

A. Alberto Hodari, M.D.
Respondent

Dated: 3-05-09

Karen Faett (P41609)
Attorney for Respondent
Dated: 3/4/09

mar09.cases.hodari.p.cos

SIEMION HUCKABAY
ATTORNEYS AND COUNSELLORS AT LAW
PROFESSIONAL CORPORATION

ONE TOWNE SQUARE
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WEBSITE www.siemion-huckabay.com

February 26, 2009

Merry A. Rosenberg, Esq.
Assistant Attorney General
Licensing & Regulation Division
P.O. Box 30754
Lansing, MI 48909

ATTORNEY GENERAL
LICENSING AND
REGULATION DIVISION

FEB 27 2009

LANSING OFFICE
RECEIVED

Re: ***In the Matter of A. Alberto Hodari, M.D.***
Our File No.: RPS-70165

Dear Ms. Rosenberg:

An anesthesiologist, Marc Wittenberg, M.D., has reviewed the practice setting at each of respondent Womancare's clinics which offer anesthesia services (Lansing, Southfield, and Sterling Heights) to ensure that the anesthesia services provided at each site conform with the standard of care. To accomplish this, Dr. Wittenberg performed on-site inspections at each of the three locations and reviewed random charts at each site to evaluate that each site was appropriately equipped with all necessary equipment to anesthetize and resuscitate patients in the operating room and the post-anesthesia care unit.

Dr. Wittenberg found that the sites had the appropriate equipment. Dr. Wittenberg observed at the first facility inspected, Southfield, that laryngeal mask airways were not available, the reason being that it was the CRNAs' general practice to carry the LMA's with them in their anesthesia kit, which is typical in standard practice. So as to avoid any concern with compliance, Dr. Wittenberg suggested Womancare may wish to order laryngeal mask airways to have them on site. The LMA's were ordered and were on premises as of the date of the site visits at Sterling Heights (November 19, 2008) and Lansing (February 4, 2009). Dr. Wittenberg also recommended that all ACLS protocol drugs be available to resuscitate patients during his visit to Southfield. Dr. Wittenberg found on subsequent site visits that all ACLS drugs were available and that all sites are appropriately equipped to both anesthetize and resuscitate patients in the OR and PACU.

From the review of the miscellaneous charts, Dr. Wittenberg can attest the anesthesia record showed appropriate anesthetic agents were used and were used in appropriate amounts.

Dr. Wittenberg, from his review of the charts, believes the patients were appropriately transferred and monitored by anesthesia personnel and the registered nurses to the PACU. He verified that patients were not permitted to get off the bed and move to a chair until vital signs with confirmed two stable blood pressures. While it is not standard of care, he recommended one additional blood pressure be obtained before transfer to PACU. He also concluded length of stay in Phase I and Phase II recovery was appropriate.

Dr. Wittenberg is satisfied that the ratio of nurses to patients in the PACU complied with the standard of care. The ratio confirmed by Dr. Wittenberg is two patients to an R.N.

Further, Dr. Wittenberg verified that the decision to discharge a patient from the PACU is made by the physician performing the operative procedure. Said decision is based upon an evaluation of the vital signs and assessment of post-procedure bleeding. Dr. Wittenberg has suggested a modified Aldrete Score be adopted for discharging a patient to home.

Thank you for your attention.

Very truly yours,

Karen M. Faett

KAREN M. FAETT

KMF:ljp

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.

EXHIBIT B page 10 of 13

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
Attorney General

Merry A. Rosenberg (P32120)
Assistant Attorney General
Licensing & Regulation Division
P.O. Box 30754
Lansing, Michigan 48909
(517) 373-1146

Dated: August 6, 2007

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