STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY
DISCIPLINARY SUBCOMMITTEE

In the Matter of

REGINALD SHARPE, D.O.
License No. 51-01-010839
_____/

Complaint No. 51-15-136490
(and 51-13-128172 and
51-14-134637 consolidated)

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Erika N. Marzorati, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Reginald Sharpe, D.O. (Respondent), alleging upon information and belief as follows:

1. The Board of Osteopathic Medicine and Surgery, an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee.

2. Respondent holds a license to practice in Michigan as an osteopathic physician pursuant to Article 15 of the Code and has a current controlled substance license.

3. Section 16221(a) of the Code authorizes the Disciplinary Subcommittee to take disciplinary action against a licensee for a violation of a 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 that impairs, or may impair, the ability to safely and skillfully practice a health profession.

4. Section 16221(b)(i) of the Code authorizes the Disciplinary Subcommittee to take disciplinary action against a licensee for incompetence, which is defined in section 16106(1) as "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 16226 of the Code authorizes the Disciplinary Subcommittee to impose sanctions against a person licensed by the Board if, after the opportunity for a hearing, the Disciplinary Subcommittee determines that the licensee violated one or more subdivisions of section 16221.

FACTUAL ALLEGATIONS

6. The following background is provided for historical purposes:

   a. In December 1998, the Disciplinary Subcommittee issued a consent order requiring Respondent to pay a $2,500 fine and placing him on probation for one year with required continuing education. The case was based on Respondent improperly delegating the administration of schedule IV controlled substances.

   b. In June 2005, the Disciplinary Subcommittee issued a consent order requiring Respondent to pay a $5,000 fine and suspending his license for 120 days, followed by one year of probation with required continuing education, quarterly board member reviews, and records reviews. The case stemmed from an order of summary suspension and administrative complaint alleging Respondent left a patient unattended in recovery, in pain, and without medical attention for several hours after he could not successfully complete her abortion.

Patient 1

7. On January 11, 2008, patient 1 (numbers used to protect patient confidentiality) presented to Respondent at Sharpe Family Planning in Detroit, Michigan, for a surgical abortion.

8. An ultrasound was performed, and Respondent determined the gestational age of the fetus was approximately 15 weeks and 2 days.

9. Respondent administered 5 milligrams of Midazolam and 10 milligrams of Nubain (Nalbuphine) to the patient intravenously before the procedure, at approximately 11:25 a.m. Respondent also administered lidocaine, a local anesthetic.

10. Shortly after Respondent began the procedure, the patient began to exhibit seizure-like symptoms.

11. Respondent stopped the procedure after the patient began to seize, and called 911 after the patient developed respiratory distress.

12. In an August 28, 2014, interview with a Department investigator, Respondent admitted he perforated the patient's uterus and the patient experienced internal bleeding during the procedure.

13. Respondent failed to provide appropriate initial support to resuscitate the patient.

14. Respondent failed to include in the patient's medical record an operative report or notes about the patient's condition or vital signs during the procedure.

15. With the exception of a short narrative on an add-on sheet, Respondent failed to include in the patient's medical record any documentation regarding the

procedure itself, the complications that occurred, or any medical assistance provided to the patient following the onset of complications.

16. The patient was transferred to St. John's Hospital and Medical Center in Detroit, Michigan.

17. The patient experienced cardiac arrest en route to the hospital.

18. The patient died on January 19, 2008. The post-mortem report lists the cause of death as uterine perforation and complications.

Patient 2

19. On August 5, 2011, patient 2 presented to Respondent at Sharpe Family Planning in Detroit, Michigan, for a surgical abortion.

20. An ultrasound was performed, and Respondent determined the gestational age of the fetus was approximately 19 weeks.

21. Respondent administered 5 milligrams of Midazolam and 10 milligrams of Nalbuphine to the patient before the procedure.

22. Respondent failed to place an intravenous catheter in or administer fluids to the patient during the procedure.

23. The patient complained of strong abdominal pain during the procedure.

24. Respondent transferred the patient to Botsford Hospital in Farmington Hills, Michigan, to "rule out" a uterine perforation due to the unusual amount of pain the patient was experiencing.

25. An ultrasound performed at Botsford Hospital revealed a fetal head protruding outside the patient's uterus and a thickened endometrium. The radiology report stated, "additional retained products can't be excluded."

26. The patient was diagnosed with postoperative hemorrhage and perforation of the uterus.

27. The patient underwent a superacervical hysterectomy at Botsford Hospital due to multiple uterine perforations.

28. Respondent failed to provide appropriate cervical preparation to the patient.

29. Respondent's patient record for the patient contained several consent forms that were incomplete.

30. Respondent failed to include in the patient's medical record an operative report; notes about the patient's condition or vital signs during or after the procedure; or any documentation regarding the procedure itself, with the exception of a short narrative on an add-on sheet.

Patient 3

31. On February 27 and 28, 2014, patient 3 presented to Respondent at WomanCare of Southfield in Lathrup Village, Michigan, for a two-day pregnancy termination procedure.

32. An ultrasound was performed, and Respondent determined the gestational age of the fetus was approximately 23 weeks.

33. Respondent perforated the patient's uterus and the patient experienced internal bleeding during the procedure.

34. Respondent transferred the patient to Botsford Hospital in Farmington Hills, Michigan.

35. An ultrasound performed at Botsford Hospital revealed a uterine perforation and retained fetal parts outside the patient's uterus.

36. The patient underwent surgery to repair the perforation and remove the retained fetal cranium and tissue from the patient's abdominal cavity.

37. Respondent administered an injection of diazepam (Valium) to the patient for sedation on the first day of the procedure. Respondent erroneously documented in the anesthesia record that the medication was administered intravenously.

38. Respondent documented in the anesthesia record "sleep" sedation was provided and that diazepam, promethazine, and Demerol were administered to the patient for the dilation and curettage (D&C) procedure on the second day. Respondent failed to document the route of administration of the medication.

39. Respondent failed to document the dose of each drug administered in the anesthesia records for both days of the procedure. The "dose" column in the records instead indicates the concentration of the solution used.

40. Respondent failed to document the time the medications were administered on both days of the procedure.

41. Respondent performed the D&C procedure without having a nurse or other medical professional present while the patient was sedated.

42. Respondent failed to document the patient's condition and vital signs during the procedure.

43. Respondent failed to include in the patient's medical record evidence the patient was appropriately monitored while she was sedated.

44. Respondent failed to provide appropriate monitoring for the patient while she was sedated.

Patient 4

45. On June 16 and 17, 2014, patient 4 presented to Respondent at WomanCare of Southfield in Lathrup Village, Michigan, for a two-day pregnancy termination procedure.

46. An ultrasound was performed on June 16, 2014, and Respondent determined the gestational age of the fetus was 22 to 23 weeks.

47. Respondent documented in the anesthesia record "sleep/heavy" sedation was provided and that diazepam, promethazine, and Demerol were administered to the patient for the dilation and curettage (D&C) procedure on the second day. Respondent failed to document how the medication was administered.

48. Respondent failed to document the dose of each drug administered in the anesthesia records for both days of the procedure. The "dose" column in the records instead indicates the concentration of the solution used.

49. Respondent failed to document the time the medications were administered on both days of the procedure.

50. Respondent performed the D&C procedure without having a nurse or other medical professional present while the patient was sedated.

51. Respondent failed to provide appropriate monitoring for the patient while she was sedated.

Patient 5

52. On December 31, 2014, patient 5 presented to Respondent at Summit Medical Center in Detroit, Michigan, for a surgical abortion.

53. An ultrasound was performed, which indicated the gestational age of the fetus was approximately 16 weeks.

54. At 12:45 p.m., Respondent administered two 200-microgram tablets of misoprostol to the patient to soften and dilate her cervix and induce abortion.

55. Respondent began the dilation and extraction procedure at 2:30 p.m.

56. Respondent stopped the procedure approximately one hour later due to insufficient dilation of the patient's cervix.

57. At 3:43 p.m., Respondent administered 600 micrograms of misoprostol to further dilate the patient's cervix.

58. Respondent resumed the procedure approximately 1.5 hours later.

59. The patient's membranes spontaneously ruptured during the procedure before her cervix was sufficiently dilated.

60. Respondent transferred the patient to Detroit Medical Center's Sinai-Grace Hospital for completion of the abortion procedure and additional care.

61. Respondent failed to document the route of administration of either dose of the misoprostol in the patient's chart.

62. Respondent failed to include in the patient's medical record an operative report detailing what occurred during either of his two attempts to complete the procedure.

63. Despite the fact the patient had a prior Cesarean delivery, Respondent failed to document the location of the placenta.

COUNT I

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

COUNT II

65. Respondent's conduct as set forth above evidences that Respondent failed to conform to minimal standards of acceptable and prevailing practice as an osteopathic physician, in violation of section 16221(b)(i) of the Code.

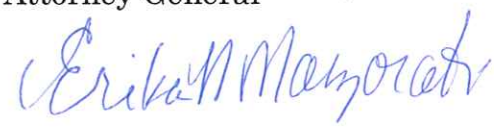
THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced

pursuant to the Public Health Code, rules promulgated thereunder, and the Administrative Procedures Act of 1969, MCL 24.201 *et seq*.

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to respond in writing to the allegations contained in it. The written response shall be submitted to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan 48909, with a copy to the undersigned assistant attorney general. Pursuant to section 16231(9), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained herein and result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully Submitted,

BILL SCHUETTE
Attorney General



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Dated: October 28, 2016

LF: 2016-0139916-A/Sharpe, Reginald D., D.O., 136490/Complaint – 2016-10-11