

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH PROFESSIONS
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

MICHAEL ARTHUR ROTH, M.D.
License No. 43-01-028327
_____ /

Complaint No. 43-11-119149

CONSENT ORDER AND
STIPULATION

CONSENT ORDER

An administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on May 17, 2012, charging Michael Arthur Roth, 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 TWO THOUSAND and 00/100 DOLLARS (\$2,000.00) to be paid by check, money order or cashier's check made payable to the State of Michigan (with complaint number 43-11-119149 clearly indicated on the check or money order) within ninety (90) days from the effective date of this order. The timely payment of the fine shall be Respondent's responsibility. Respondent shall mail the fine to: Sanction Monitoring, Bureau of Health Professions, Department of Licensing and Regulatory Affairs, P.O. Box 30185, Lansing, Michigan 48909.

Count I, alleging a violation of sections 16221(a), (b)(i) and (b)(vi) of the Public Health Code, and paragraphs 29 and 30, alleging violations of sections 16221(b)(i) and (b)(vi) of the Code, are DISMISSED.

Respondent shall be responsible for all costs and expenses incurred in complying with the terms and conditions of this consent order.

Respondent shall be responsible for the timely compliance with the terms of this consent order, including the timely filing of any documentation. Failure to comply within the time limitations provided will constitute a violation of this order.

If Respondent violates any term or condition set forth in this order, Respondent will be in violation of 1996 AACRS, 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 December 17, 2012

MICHIGAN BOARD OF MEDICINE

By Carol H. Lunde
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.

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 Richard D. Bates, M.D. Dr. Bates or an attorney from the Licensing and Regulation Division may discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

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

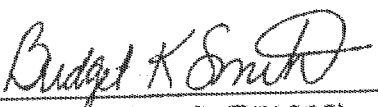
- A. Respondent has been practicing as an obstetrician/gynecologist for over thirty years and during the September 19, 2012 compliance conference demonstrated that he is knowledgeable and well versed in the performance of dilation and evacuation procedures (D and E).
- B. During the compliance conference Respondent explained that following L.H.'s February 16, 2008 D and E he asked staff to observe her in the recovery room for any additional complications. As a result, L.H. spent three hours in the recovery room and Respondent reported during that time L.H. exhibited no symptoms that would suggest she had suffered a perforation during the D and E. Further, when L.H. attempted to use the restroom and suffered a second fainting episode, Respondent immediately called for emergency personnel when it was clear that he was unable to restart L.H.'s IV.
- C. Respondent also explained that he immediately contacted the Sinai-Grace Emergency Department (Sinai) to inform them of L.H.'s symptoms and notify them that she was on her way to the hospital. Contrary to the allegations of the complaint, Respondent explained that he made it clear to the Emergency Room Physician that L.H. could be experiencing complications from the D and E and that an OB/GYN consultation might be appropriate.

- D. During the compliance conference, Respondent also explained that he contacted Sinai on several occasions to check on L.H.'s progress and attempted to contact Summit Medical Center's Medical Director, who had privileges at Sinai. However, Respondent stated that he was unable to reach the Medical Director before L.H. checked herself out of the hospital.
- E. Based on Respondent's explanation at the compliance conference, Dr. Bates and the parties agreed that Respondent's treatment and follow-up care of L.H. was appropriate under the circumstances and did not constitute a violation of the Public Health Code.
- F. During the compliance conference, Respondent explained that he was an independent contractor with the Woman Care Clinic and as a result was not responsible for scheduling patients. He stated that the Woman Care staff provided notice when he was needed at the clinic for appointments. As a result, Respondent explained he was unaware that B.S. and her husband had been scheduled to see him on January 14, 2011 and in fact, because January 14, 2011 was a Friday, he would have been scheduled to see patients in his own office and not at Woman Care Clinic.
- G. During the compliance conference, Respondent explained that he was unable to complete B.S.'s D and E because Woman Care Clinic had run out of the size of dilators that he would typically feel comfortable using for that procedure. Respondent explained that he was embarrassed of the situation and believed the staff could handle the conversation with B.S. more delicately than he could have. However, Respondent recognizes that he should have sat down and talked to B.S. and her husband about his decision to delay the D and E procedure, and regrets that he chose to leave the clinic without doing so.
- H. During the compliance conference Respondent indicated that because of the issues with scheduling and lack of appropriate instruments, he no longer works with Woman Care Clinic.

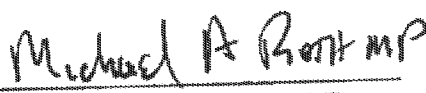
5. This consent order incorporates the conditions of a counteroffer made by the Disciplinary Subcommittee at its meeting held on November 21, 2012.

By signing this stipulation, the parties confirm that they have read,
understand and agree with the terms of the consent order.


AGREED TO BY:


Bridget K. Smith (P71318)
Assistant Attorney General
Attorney for Complainant
Dated: 12/13/12

AGREED TO BY:


Michael Arthur Roth, M.D.
Respondent

Dated: 12/5/12


Jonathan C. Lanesky (P59740)
Attorney for Respondent
Dated: 12/5/12

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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH PROFESSIONS
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

MICHAEL ARTHUR ROTH, M.D.
License No. 43-01-028327

Complaint No. 43-11-119149
/ (Consolidated with No. 43-09-114385)

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Bridget K. Smith, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Health Professions (Complainant), files this complaint against Michael A. Roth, 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. Respondent is currently licensed to practice Medicine pursuant to the Code. At all times relevant to this complaint, Respondent was employed by Summit Medical Center (Summit), in Detroit, Michigan and WomanCare Clinic

(WomanCare), in Lathrop Village, Michigan. In addition, Respondent owns and operates his own practice, which is located in Novi, Michigan.

3. Section 16221(a) of the Code provides the DSC with the authority to take disciplinary action against a licensee 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 that impairs, or may impair the 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 a licensee for incompetence, which is defined in section 16106(1) of the Code to mean "a departure from, or failure to conform to minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs."

5. Section 16221(b)(vi) of the Code provides the DSC with authority to take disciplinary action against a licensee for 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 sanctions against persons licensed by the Board if, after opportunity for a hearing, the DSC determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

GENERAL ALLEGATIONS

COUNT I

Patient L.H.

7. On February 13, 2008, L.H. (initials used to protect patient confidentiality), a female (D/O/B 10/24/84), contacted Summit to schedule an appointment for termination of her pregnancy. Summit staff scheduled L.H. for an appointment on February 15, 2008. In addition, staff faxed L.H. a written summary of the termination procedure, a description of the fetus, and a copy of a pre-natal care and parenting information pamphlet, in accordance with section 17015 of the Code.

8. On February 15, 2008, L.H. arrived at Summit for her first appointment. At that time, L.H. was counseled by a member of the Summit Staff, who performed an ultrasound and confirmed L.H. was 22 weeks pregnant. Summit staff then sent L.H. to Respondent's Novi office to begin the two-day dilation and evacuation procedure (D and E).

9. At Respondent's Novi office, Respondent gave L.H. a physical exam. After re-confirming that L.H. was 22 weeks pregnant, Respondent began the D and E.

10. The first day of the procedure was without incident. Following the procedure, Respondent's staff gave L.H. instructions on what to do that evening and advised her to return to Summit the next day to complete the D and E.

11. On February 16, 2008, L.H. returned to Summit for completion of the D and E. Prior to starting the procedure, Respondent placed L.H. under intravenous (IV) sedation and monitored her vitals. Respondent then began the second part of the D and E procedure.

12. According to Respondent's February 16, 2008 progress note, at some point during the procedure, L.H. experienced a syncopal episode (fainting). Respondent aroused L.H. with smelling salts and completed the procedure.

13. According to the February 16, 2008 progress note, following the completion of the procedure, L.H.'s blood pressure, pulse and bleeding were normal and L.H. was responsive. Accordingly, Respondent discharged L.H. to the recovery area at 11:15 a.m.

14. At 3:02 p.m., L.H. got up to go to the bathroom where she experienced heavy vaginal bleeding and fainted a second time. Respondent was able to arouse L.H. using smelling salts, but was unable to initiate an IV. Accordingly, Respondent contacted EMS and L.H. was transported to nearby Sinai-Grace hospital. That was the last contact Respondent had with L.H.

15. According to the February 16, 2008 Sinai-Grace Emergency Department Note, Respondent contacted the emergency department physician and notified him or her that L.H. had suffered two episodes of syncope while at Summit. Nothing in the Emergency Department Note indicates that Respondent suggested he may have perforated L.H.'s uterus during the D and E. Further, nothing in Respondent's records for L.H. indicate that he considered uterine perforation as a possible cause for L.H.'s distress, despite the fact that perforation is a known complication of second trimester pregnancy terminations and would account for L.H.'s blood loss and syncopal episodes.

16. Further, Respondent made no effort to contact Sinai-Grace's staff gynecologist/obstetrician to inform them that L.H. was being transferred to their hospital with potentially serious gynecological complications.

17. On February 17, 2008, L.H. checked herself out of Sinai-Grace and presented herself to St. Vincent Mercy Medical Center in Toledo, Ohio. On

February 18, 2008, doctors at St. Vincent determined that L.H. had a possible uterine perforation and scheduled L.H. for exploratory surgery. During the surgery, the surgeon found a laceration on the right side of L.H.'s uterus, consistent with perforation during the D and E. Ultimately, the surgeon at St. Vincent performed a total hysterectomy on L.H.

18. Respondent's failure to recognize and treat L.H. for a possible uterine tear, as well as his failure to provide L.H. with appropriate follow-up care was below standards of care for physicians licensed to practice medicine in the State of Michigan.

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

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

21. Respondent's conduct as described above evidences a lack of good moral character in violation of section 16221(b)(vi) of the Code.

Count II

Patient B.S.

22. In January, 2011, a genetic counselor referred B.S., female (D/O/B 5/20/71), and her husband J.S., to WomanCare for a pregnancy termination procedure.

23. On January 14, 2011, B.S. had an initial appointment at WomanCare. During that appointment, B.S. filled out paperwork and a technician performed an ultrasound. Following the ultrasound, WomanCare staff informed B.S. and J.S. that Respondent failed to appear at the clinic to perform the procedure. WomanCare staff rescheduled the procedure for January 17, 2011.

24. At 2:00 p.m. on January 17, 2011, B.S. and J.S. returned to WomanCare to begin the termination procedure. They waited until 5:00 p.m. until staff finally called B.S. back to an exam room. Staff gave B.S. a gown and allowed her to change for the procedure.

25. At some point, Respondent entered B.S.'s exam room, briefly reviewed B.S.'s chart and then left the room. Respondent said nothing to B.S., nor did he speak to J.S., who remained in the waiting room. Eventually a staff member informed B.S. that Respondent had left WomanCare and would not be performing the termination procedure that day.

26. Respondent's failure to explain the reason for non-treatment and discuss alternatives with B.S. was below standards of care for physicians licensed to practice medicine in the State of Michigan.

27. On January 20, 2011, B.S. underwent a pregnancy termination procedure at another facility with another physician.

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

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

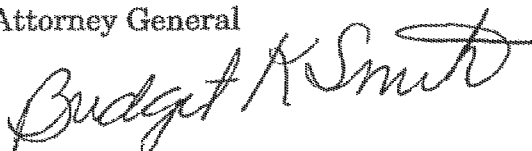
30. Respondent's conduct as described above constitutes a lack of good moral character, in violation of section 16221(b)(vi) of the Code.

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 pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*; MSA 3.560(101) *et seq*.

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 Professions, Department of Licensing and Regulatory Affairs, 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,

BILL SCHUETTE
Attorney General

A handwritten signature in cursive script, appearing to read "Bridget K. Smith".

Bridget K. Smith (P71318)
Assistant Attorney General
Licensing & Regulation Division
525 W. Ottawa, 3rd Floor Wms Bldg
P.O. Box 30758
Lansing, Michigan 48909
(517) 373-1146

Dated: May 17, 2012

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

In the Matter of

MICHAEL ARTHUR ROTH, M.D.
_____ /

Complaint No. 43-00-2832-00
CONSENT ORDER AND STIPULATION

CONSENT ORDER

An Administrative Complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on October 15, 2003, charging Michael Arthur Roth, 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 sections 16221(a), (b)(i), and (b)(vi) of the Public Health Code.

Accordingly, for these violations, IT IS ORDERED:

Respondent is placed on PROBATION for a period of six months commencing on the effective date of this Order. Reduction of the probationary period shall occur only while

Respondent is employed as a medical doctor. Respondent shall be automatically discharged from probation at the end of the probationary period provided Respondent has complied with the terms of this Order. The terms and conditions of the probation with which Respondent must complete within the period of probation are as follows:

- A. MEETING WITH BOARD MEMBER OR DESIGNEE. Respondent shall meet quarterly with a Board member or a designee named by the Board Chairperson to review Respondent's professional practice. The initial meeting shall occur at the beginning of probation and subsequent meetings as deemed necessary by the reviewer, but at least quarterly until the period of probation ends. Within fifteen days of this Order's effective date, Respondent shall contact the Sanction Monitoring Unit (Unit) of the Bureau of Health Services, Department of Community Health at (517) 373-4972. The Unit shall provide Respondent with the name of and contact information for the designated person. Respondent shall be responsible for scheduling the time and place of his meetings with this individual.
- B. RECORDS REVIEW. During the period of probation, the designated physician shall review records of patients treated by Respondent on both an inpatient and outpatient basis. This review may occur at the quarterly meetings described in the above paragraph.
- C. CONTINUING EDUCATION CREDITS. Respondent shall successfully complete continuing education (CE) credits in the areas of bariatrics and proper medical documentation. These hours shall not count toward the number of credit hours required for license renewal. Respondent must seek and obtain advance approval of the CE course from the Board Chairperson or his designee. Respondent shall mail his request for course approval and proof of successful course completion to the Department at the address set forth below.
- D. WEIGHT MANAGEMENT PLANS. Respondent shall submit an approved weight management plan for use in his office practice to a Board approved physician for review. This plan shall include at a minimum, nutritional guidelines, exercise routines, a schedule for patients to meet goals, proper patient follow-up, proper chart documentation, and a timeframe in which the use of scheduled medications will no longer be used for weight loss.
- E. REPORTING PROCEDURE. The designated reviewer described above shall issue reports to the Department advising of Respondent's work performance. These reports shall also include an evaluation of

Respondent's charts with respect to the adequacy of his documentation. The first report shall be filed at the end of the first month of probation, and subsequent reports as deemed necessary by the reviewer, but at least quarterly until Respondent is discharged from probation. In addition to receiving reports as required above, the Department or its authorized representative may periodically contact the reporting individual to inquire of Respondent's progress. By accepting the terms of this Consent Order and Stipulation, Respondent has authorized the release of all necessary records and information.

- F. PHARMACY INSPECTIONS. Respondent shall be subject to random inspections by a Department of Community Health's pharmacy inspector. The inspector shall then file a report detailing Respondent's compliance with all applicable statutory requirements and rules governing his drug control license.

Respondent is FINED \$15,000.00 to be paid by check, money order or cashier's check made payable to the State of Michigan (with Complaint number 43-00-2832-00 clearly indicated on the check or money order) within six months from the effective date of this Order. The timely payment of the fine shall be Respondent's responsibility.

Respondent shall direct any communications to the Department that are required by the terms of this Order, except the payment of fines, to: Sanction Monitoring Unit, Bureau of Health Professions, Department of Community Health, P.O. Box 30670, Lansing, Michigan 48909. Respondent shall mail any 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.

Respondent shall be responsible for the timely compliance with the terms of this Consent Order, including the timely filing of any documentation, and the failure to comply within the time limitations provided will constitute a violation of this Order.

If Respondent violates any term or condition set forth in this order, Respondent will be in violation of 1996 AACRS, 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 May 19, 2004.

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.

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.

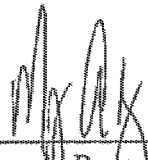
3. The Disciplinary Subcommittee may enter the above Consent Order, which Board conferee Scot F. Goldberg, M.D. supports. The Board conferee and the undersigned Assistant Attorney General are free to discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

4. The Board conferee and the parties considered the following factors in reaching this agreement:

- A. Respondent has cooperated fully in the resolution of this matter.
- B. There has been no patient harm as a result of Respondent's conduct described in the State's Administrative Complaint.
- C. Respondent will never perform a pregnancy termination procedure outside an approved clinic/hospital/office setting. Respondent understands his office practice will continue to be subject to random pharmacy inspections after his probation period ends.


5. Should the Disciplinary Subcommittee reject the proposed consent order, the parties reserve the right to proceed to hearing.

AGREED TO BY:

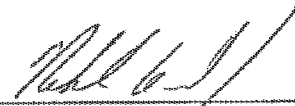


Merry A. Rosenberg (P32120)
Assistant Attorney General
Attorney for Complainant
Dated: 4/22/04

AGREED TO BY:



Michael Arthur Roth, M.D.
Respondent
Dated: 4-15-04

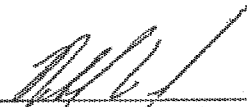


Nicholas A. Ianni, Jr. (P34486)
Attorney for Respondent
Dated: 4-15-04

State of MICHIGAN)

County of WASHTENAW)

On APRIL 15, 2004, I observed Michael Arthur Roth, M.D., sign this Stipulation.



Notary Public, WASHTENAW County
State of MICHIGAN
My commission expires: 1/13/05

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STATE OF MICHIGAN
DEPARTMENT OF CONSUMER & INDUSTRY SERVICES
BUREAU OF HEALTH SERVICES
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

MICHAEL ARTHUR ROTH, M.D.

Complaint No. 43-00-2832-00

ADMINISTRATIVE COMPLAINT

Attorney General Michael Cox, through Assistant Attorney General Merry A. Rosenberg, on behalf of the Department of Consumer & Industry Services, Bureau of Health Services, (Complainant), files this Complaint against Michael Arthur Roth, 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, 1978 PA 368, as amended; MCL 333.1101 *et seq.*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee (DSC).
2. Respondent is currently licensed to practice medicine pursuant to the Code and, at all times relevant to this Complaint, was board certified in obstetrics and gynecology.
3. Section 16221(a) of the Code provides the DSC with authority to take disciplinary action against Respondent 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, the 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 sanctions against a person licensed by the Board if, after opportunity for a hearing, the DSC determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

COUNT I

7. M.M., (initials will be used to protect patient confidentiality), a 29-year old female, presented to Respondent's office on March 14, 2000, for a voluntary termination of pregnancy. Respondent performed an ultrasound, which he interpreted to show a gestational age of 23 to 24 weeks.

8. Respondent inserted the laminaria for the procedure that same day; M.M. returned to his office the next day, March 15, 2000, to have the procedure completed. His chart for M.M. does not include a pre-operative hemoglobin and hematocrit, any record of her pulse, a recovery record, or a discharge record with discharge instructions.

9. Respondent's conduct described in paragraphs 7-8 above constitutes negligence, in violation of section 16221(a) of the Code.

10. Respondent's conduct described in paragraphs 7-8 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT II

11. M.E., a 41-year old female, requested Respondent to perform a voluntary termination of pregnancy at her home on or about December 6, 1998. She wanted the procedure done at her home because of her alleged agoraphobia, although Respondent's chart was devoid of any documentation to support that diagnosis. In fact, M.E. identified herself as a "bartender."

12. Respondent performed the termination procedure at M.E.'s home on December 6, 1998. Respondent's chart for M.E. does not include any verification of her age or identity, (i.e., a driver's license), or the consent form that verifies the statutorily required 24-hour waiting period. In fact, this record does reflect that Respondent never saw her before performing the procedure.

13. Respondent's records for M.E. are further devoid of any documentation of a history and physical, pre-procedure hemoglobin or hematocrit, vital signs taken before, during or after the procedure, a recovery record, or discharge instructions.

14. Respondent performed a second voluntary termination of pregnancy on M.E. at her home on October 5, 1999, again because of her alleged agoraphobia. As noted, (paragraph 12 *supra*,) the chart includes no documentation of her identity or age, or that she was seen by Respondent prior to the procedure to receive the statutorily required 24-hour consent information.

15. Respondent's records for the October 5, 1999, procedure do not include a history or physical, a pre-operative hemoglobin or hematocrit, a recovery record, or discharge instructions.

16. Respondent's conduct described in paragraphs 11-15 above constitutes negligence, in violation of section 16221(a) of the Code.

17. Respondent's conduct described in paragraphs 11-15 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT III

18. N.F. began treatment with Respondent on June 27, 1997. Respondent performed a dilatation and curettage on June 3, 1998. Respondent's record for that procedure does not include documentation of any vital signs, except for her pre-operative blood pressure.

19. N.F. became pregnant in September of 1999. Respondent performed ultrasounds on October 8, 1999, October 18, 1999, November 2, 1999, November 12, 1999, November 24, 1999, December 1, 1999, and January 12, 2000. Additionally, maternal fetal specialist William Blessed, M.D., performed ultrasounds on N.F. on October 20, 1999, and December 30, 1999. There is no medical justification in Respondent's chart for the ultrasounds Respondent performed on November 12, 1999, November 24, 1999, and January 12, 2000.

20. Respondent's conduct described in paragraphs 18-19 above constitutes negligence, in violation of section 16221(a) of the Code.

21. Respondent's conduct described in paragraphs 18-19 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

22. Respondent's conduct described in paragraphs 18-19 above constitutes a lack of good moral character, in violation of section 16221(b)(vi) of the Code.

COUNT IV

23. K.Y., a 42-year old female, presented to Respondent's office on November 22, 1999, for weight loss. She weighted 176 pounds at that time. K.Y. continued to see Respondent for that purpose until April 18, 2001. During that 16-month period, she lost only 6½ lbs, despite receiving bi-monthly supplies of Phentermine and Chromium from Respondent.

24. Respondent provided B₁₂ injections to K.Y. beginning November 22, 1999, and continuing throughout the rest of her care with him, even though his chart includes only one set of laboratory tests which were performed on her initial visit and did *not* reflect a vitamin B₁₂ deficiency.

25. Respondent's chart for K.Y. is devoid of any documentation of the diet plan that K.Y. was following, a nutrition assessment, counseling, or any other documentation of the regimen she was to follow.

26. Respondent's conduct described in paragraphs 23-25 above constitutes negligence, in violation of section 16221(a) of the Code.

27. Respondent's conduct described in paragraphs 23-25 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT V

28. S.K. began to treat with Respondent in June of 1989. For the period July 1996 through September 13, 2000, Respondent's chart reflects approximately 31 interactions with S.K. Of those visits, four physical examinations are documented: December 9, 1997; July 21, 1998; June 11, 1999; and July 28, 1999. Her chart otherwise includes call-ins to the pharmacy for prescriptions, including multiple antibiotics with no rationale, multiple schedule four sedatives with no rationale, multiple pain medications with no rationale, multiple migraine type medications with no rationale and multiple cardiac-type medications with no rationale.

29. Respondent's conduct described in paragraph 28 above constitutes negligence, in violation of section 16221(a) of the Code.

30. Respondent's conduct described in paragraph 28 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT VI

31. C.D., a 40-year old female, presented to Respondent's office on April 30, 1997, for weight loss. She weighed 140 lbs. Respondent prescribed Chromium and Phentermine at that visit.

32. Although C.D. continued to treat with Respondent through March 6, 2001, it appears that her last visit for weight control was on August 2, 2000, at which time no weight was

recorded. The next time her weight was recorded was on February 21, 2001, at which time she weighed 159 lbs, a 19-pound weight gain from her initial visit.

33. Respondent's chart for C.D. is devoid of any documentation of the diet plan that C.D. was following, a nutrition assessment, counseling, or any other documentation of the regimen she was to follow

34. Respondent's conduct described in paragraphs 31 through 33 above constitutes negligence, in violation of section 16221(a) of the Code.

35. Respondent's conduct described in paragraphs 31-33 above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT VII

36. Consumer and Industry Services' Pharmacy Inspector Carol Haynes-Hall conducted an office inspection of Respondent's office on January 3, 2002. At that time, she noted that Respondent's drug control license expired on June 30, 1981. After this inspection, Respondent updated his license and now has a current drug control license. Additionally, Respondent's medical license was not posted in his office.

37. Ms. Haynes-Hall further noted the presence of approximately 200 to 300 envelopes in a cabinet to which Respondent's staff had access. These envelopes contained

misbranded medications, including the controlled substances Phentermine, Diethylpropion, and Phendimetrazone.

38. Inspector Haynes-Hall further noted that the above-described envelopes were not properly labeled, lacked expiration dates for the enclosed medications, and lacked any required caution statements. They also did not have proper safety closures.

39. The logbook maintained in Respondent's office for these medications did not include their lot number and expiration date. Respondent also failed to maintain either a perpetual or an annual inventory.

40. Respondent's medical assistant Chris Threet told Consumer and Industry Services' Investigator Danene Nunez during an interview on January 3, 2002, that she dispensed controlled diet substance medications to Respondent's patients when he was not present in the office.

41. Respondent's conduct described in paragraphs 36-40 above constitutes negligence, in violation of section 16221(a) of the Code.

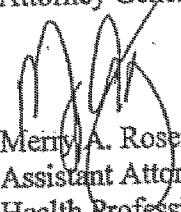
THEREFORE, Complainant requests that this Complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced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

pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq.*

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 Consumer & Industry Services, 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 Cox
Attorney General



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Dated: October 15, 2003
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