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

In the Matter of

Reginald D. Sharpe, D.O.
_____/

Complaint No. 51-05-98202

ADMINISTRATIVE COMPLAINT

Attorney General Michael A. Cox, through Assistant Attorney General Thomas P. Scallen, on behalf of the Department of Community Health, Bureau of Health Professions (Complainant), files this Administrative Complaint against Reginald D. Sharpe, D.O. (Respondent), alleging upon information and belief as follows:

1. The Board of Osteopathic Medicine and Surgery (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 licensed to practice osteopathic medicine and surgery in Michigan. At all times pertinent to this Administrative Complaint, he practiced osteopathic medicine and surgery in Livonia.

3. Section 16221(a) of the Code authorizes the DSC 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, Respondent's ability to safely and skillfully practice osteopathic medicine and surgery.

4. Section 16221(b)(i) of the Code authorizes the DSC to take disciplinary action against Respondent 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 authorizes the Board's DSC to take disciplinary action against Respondent's license for a lack of good moral character. Good moral character is 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.

7. Section 16233(5) of the Public Health Code, 1978 PA 368, as amended, MCL 333.1101*et seq*, provides Complainant with authority, after consultation with the Chairperson of the Board of Osteopathic Medicine and Surgery, to summarily suspend Respondent's license to practice osteopathic medicine and surgery if the public health, safety, or welfare requires emergency action in accordance with section 92 of the administrative procedures act of 1969, MCL 24.292.

8. On or about February 24, 2005, patient R.C. (initials are used for the purpose of confidentiality), 31 years old and pregnant for the sixth time (four births), presented to Rudolfo Finkelstein, M.D., at the Women's Advisory Center ("the Center") for an abortion consultation,

which included an ultrasound. After performing the ultrasound, Dr. Finkelstein informed R.C. that she was 23.5 weeks along and needed to have the pregnancy terminated immediately.

9. On March 1, 2005, R.C. presented to the Center to have an abortion. Dr. Finkelstein placed the laminaria in R.C.'s cervix as the first part of a two-day outpatient procedure. When R.C. returned to the Center at 9:00 a.m. on March 2, Respondent informed R.C. that he would complete the abortion procedure, as Dr. Finkelstein was not available.

10. Respondent injected R.C. with a sedative, and began the suctioning process. After a few minutes of suctioning, however, Respondent advised R.C. that he was unable to access the fetus because it was too far up, and that she should just rest quietly for awhile. R.C. was directed to the "recovery room" and left alone to rest. Respondent checked on R.C. about 15 minutes later, and then left the Center.

11. During the course of the next few hours, R.C. began to have contractions and bleed profusely. As her pain increased and condition deteriorated, R.C. repeatedly told the two medical assistants at the Center – neither of whom was a licensed health professional – that she required medical assistance and needed to see Respondent. Each time the medical assistants told R.C. that Respondent would return shortly; the only assistance they provided was to move R.C. to another bed in the recovery room and change the bloodied bedding. Further, R.C. asked the medical assistants several times to either call an ambulance or allow her mother, who was in the Center's waiting room, to come into the recovery room. Each time the medical assistants refused R.C.'s requests to call an ambulance or see her mother.

12. At approximately 12:20 p.m., roughly three hours after Respondent had left the Center, R.C., not having received any medical attention for her pain, contractions or profuse bleeding, screamed for her mother. Because R.C.'s mother heard the screams, the medical

assistants relented and allowed her entry into the recovery room to see her daughter. R.C., who was crying and bleeding when her mother entered the recovery room, told her mother that her contractions were "on top of each other" and that she had to start pushing. R.C.'s mother immediately observed that the fetus was crowning and asked the medical assistants to assist her in helping R.C. to deliver the fetus. When the medical assistants refused to help, R.C.'s mother proceeded alone to help R.C. deliver the fetus, which upon delivery showed no signs of life.

13. Immediately following R.C.'s delivery of the fetus, R.C.'s mother asked the medical assistants to call an ambulance. The medical assistants declined. R.C.'s mother then called the Oakland County EMS (EMS) on her cell phone. EMS received the call from R.C.'s mother at approximately 1:23 p.m. and arrived at the Center at 1:31 p.m. The EMS paramedics then waited eight minutes – until 1:39 p.m. – before one of the medical assistants opened the Center's locked door. The Center's medical assistant advised the EMS paramedics that their assistance was not necessary because Respondent was en route to the Center. When the EMS paramedics insisted on seeing R.C., the medical assistant reluctantly permitted them to enter the Center.

14. Just before the EMS paramedics gained entry to the Center – but after R.C. had delivered the fetus – Respondent spoke with R.C.'s mother by telephone, advising her that what had occurred was "normal" and that she shouldn't worry, as he was only "five minutes away" from the Center.

15. R.C., with the cord to the fetus still attached, advised the EMS paramedics that she wished to be transported to a hospital. The paramedics took R.C.'s vitals at 1:40 p.m. (blood pressure - 82/61; pulse rate - 146; and respiration rate - 20), and again at 1:52 p.m. (blood pressure - 90/66; pulse rate - 124; and respiration rate - 20). The EMS paramedics placed R.C. on a stretcher at 1:55 p.m. – more than 15 minutes after Respondent had advised R.C.'s mother

that he was "five minutes away" – and departed the Center. In order to avoid a confrontation with Respondent, who had informed the EMS paramedics by telephone that he was en route to the Center and had demanded that they not take R.C. to a hospital, the EMS paramedics drove to a parking lot a block down from the Center in order to check R.C.'s vitals. By this time it was 1:57 p.m., and R.C.'s vitals were: blood pressure - 104/64; pulse rate - 120; and respiration rate - 20. EMS then rushed R.C. to the Botsford Hospital ER, arriving at 1:59 p.m. The hospital's health professionals stabilized R.C., severed the cord, attended to the delivery of the placenta, and assessed the fetus at 27 weeks gestation.

COUNT I

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

COUNT II

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

COUNT III

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

FURTHER, Complainant requests that pending the hearing and final determination Respondent's license to practice osteopathic medicine and surgery in the state of Michigan be summarily suspended pursuant to section 92 of the Administrative Procedures Act and section 16233(5) of the Public Health Code for the reason that, based upon the allegations set forth herein, to permit Respondent to continue to practice the profession constitutes a danger to the public health, safety and welfare requiring emergency action.

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

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