Abortion Abuses
and
State Regulatory Agency Failure

Right to Life of Michigan
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Introduction

Decades of documentation reveal a pattern of deeply entrenched illegal and unethical practices throughout Michigan's abortion industry. Michigan has 32 known surgical abortion facilities, employing about 20 medical doctors and osteopathic physicians. In the absence of any meaningful state enforcement, these facilities and their staff routinely violate state law, administrative regulations, professional standards of conduct, and common decency.

The state agencies with oversight authority have abdicated their responsibility to the Michigan public. Michigan law has established minimum health and safety standards for medical professionals and surgical facilities. These statutes are intended to protect the public health. However, the Bureau of Health Systems, the Bureau of Health Professions, and the Department of Environmental Quality have failed to fulfill their statutory duty to enforce these laws. For decades, the abortion industry has operated in an enforcement vacuum, evading mandated state licensure, cutting costs through heinous medical waste disposal practices, ignoring laws regulating controlled substances, and harming patients through substandard facilities and medical staff negligence.

This report documents the abuses, and sheds light on state agency failure to enforce the law. It also offers recommendations going forward. The legislature and state administration can combat these entrenched abuses. Reform begins with a clear understanding of the illegal activity that has become standard business practice for Michigan abortion clinics, and a detailed examination of the failure to curb these abuses by the agencies charged with safeguarding the public health.

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Executive Summary

Part I of this report provides an overview of decades of abuses at abortion clinics, demonstrating a pattern and practice of gross violations throughout the industry:

- Illegal biohazard waste disposal and breaches of medical record privacy,
- Negligent operative and post-operative practices that result in patient injury and death,
- Refusals to release medical records for patient use and patient follow-up care,
- Failure to report to the state medical complications, including patient deaths,
- Illegal drug prescription, storage, and administration practices,
- Failure to ensure sterile, sanitary surgical equipment and a sterile operative environment,
- Violations of the law regarding informed consent for abortions, and
- Performance abortions past the point of viability without documentation of a maternal health reason.

Part II details systematic failures by the Bureau of Health Systems to ensure that abortion clinics are licensed and operating according to state surgical facility standards. Only 4 of the 32 surgical abortion facilities hold current state licensure as freestanding surgical outpatient facilities, though all meet the criteria requiring licensure. The Bureau of Health Systems ignores reports of facilities operating without licensure, fails to conduct statutorily mandated inspections for those clinics that do seek a license, and fails to take consistent action when a facility falls out of compliance with licensure standards.

Part III reveals failures by the Bureau of Health Professions and medical licensing boards, particularly the Board of Medicine, to keep unsafe physicians from practicing in Michigan. The Bureau of Health Professions misses statutorily-mandated timelines in a troubled allegation investigation and litigation process. Deficiencies in that process create barriers to identifying patterns of bad practice, and result in board members single-handedly making critical decisions with no input from other board members or department oversight. The previous Board of Medicine president took advantage of these deficiencies, inappropriately reviewing cases instead of recusing himself, and rendering questionable dismissals of patient allegations. In addition, the licensing boards levy paltry fines that fail to recoup state expenses and deter bad practice.

Part I: The Abortion Landscape in Michigan—A History of Abuses

Decades of documented abuses at abortion clinics demonstrate a pattern and practice of gross violations throughout the industry. Sections 1-8 detail how abortion clinics (1) routinely violate biohazard waste disposal and medical record privacy laws, (2) maintain negligent operative and post-operative practices that have resulted in patient injury and death, (3) refuse to release medical records for patient use and patient follow-up care, (4) fail to report complications to the state, (5) violate state controlled substance regulations for drug storage and administration, (6) fail to ensure sterile, sanitary surgical equipment and a sterile operative environment, (7) violate the law regarding informed consent for abortions, and (8) perform abortions past the point of viability without documentation of a maternal health reason.

Section 1: Illegal Dumping of Biohazard Waste, Patient Records, and Fetal Remains

Over two decades of evidence reveals a pattern and practice of illegal waste disposal throughout the abortion industry. Abortion clinics show blatant disregard for state, federal and local laws regarding disposal of biohazard waste and patient records. They routinely dump in common trash receptacles extensive patient medical information, biohazard waste such as bloody surgical equipment, and fetal remains. Weak state enforcement fails to deter these heinous breaches of waste disposal and patient confidentiality laws.

Documentation of illegal waste disposal spans several decades as summarized in Table 1.

In 1989, the prolife group Rescue Lansing found the remains of 47 aborted babies in the business dumpster outside a Lansing building housing two abortion clinics.[1] All aborted babies were in containers labeled with the full names of the women. The two clinics in question, WomanCare, owned by abortion doctor Alberto Hodari; and Health Care Clinic, administered by Maggie Remund, both denied that they disposed of fetuses by throwing them in the trash. The state Bureau of Health Facilities, the precursor to the Bureau of Health Systems, investigated and turned over their findings to the Attorney General, with a recommendation that Health Care Clinic be cited for medical waste violations.[2] Attorney General Frank Kelley did not pursue the case, due to problems with the handling of the evidence, according to the A.G.'s spokesman.[3] Neither clinic was fined.

Because the state did nothing to deter these illegal dumping practices, flagrant abuses of the law continued.

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[1] Miner, Betsy. "Lansing Abortion Clinics Deny They Put Fetuses in Trash." *Lansing State Journal*. January 19, 1990.

[2] Miner, Betsy. "State Ends Probe of Fetus-Disposal Charges." *Lansing State Journal*. April 11, 1990.
Beltz, Donna J. "Health Department Report." Editorial for *Lansing State Journal*. August 19, 1990.

[3] Makinen, Tim. "State Will Not Try Fetus Case." *Lansing State Journal*. May 10, 1990.

Table 1
Illegal Disposal at Michigan Abortion Clinics
1989-2010

Date	Clinics	Owner/Operator	Illegal Disposal	Enforcement Actions
July 1989	• WomanCare, Lansing • Health Care Clinic, later renamed Womans Choice and moved to Delta Twp., Lansing	Owner WomanCare: Alberto Hodari Operator Health Care Clinic (later renamed Womans Choice): Richard & Maggie Remund	Remains of 47 aborted babies with full names of mothers on containers, patient records, bloody surgical material Both clinics in same building & used same dumpster.	MI Bureau of Health Facilities investigates, turns over findings to Atty. General Kelley with recommendation that Health Care Clinic be cited for medical waste violations. *A.G. Kelley decides not to pursue case*, cites problems with the handling of evidence.
Feb. 2008	• WomanCare of Southfield, Lathrup Village • WomanCare Inc., Sterling Heights • WomanCare of Downriver, Southgate	Owner: Alberto Hodari	Remains of 18 babies, 200+ patient records including insurance forms and photocopies of driver's licenses, bloody surgical material	• MI DEQ investigates, tells owner to retrain staff, *no fines or penalties* • MI Bureau of Health Professions investigates, *determines no violation of Public Health Code* • Federal Office of Civil Rights investigates, substantiates allegation of HIPPA violation, *no fines or penalties* • Oakland Co. Prosecutor's Office charges Hodari with 12 misdemeanor counts of improperly disposing medical records at WC of Southfield. Charges dismissed after payment of $100 fine.
April 2008	Eastpointe Gynecology, Detroit	Owner: Jacob Kalo	40-50 patient records, used syringes, bloody surgical material	• Report filed with Detroit Police, *no charges* • Federal Office of Civil Rights investigates, substantiates allegation of HIPPA violation but *no fines or penalties*
April 2008	• Women's Advisory Center, Livonia • Sharpe's Family Planning (Women's Advisory Center), Detroit	Owner: Reginald Sharpe	Remains of 10 babies, total of 30-40 patient records, bloody surgical material	• MI DEQ investigates, cites 5 violations of Medical Waste Regulatory Act at Livonia location. *no fines or penalties* • MI Bureau of Health Professions investigates, *determines no violation of Public Health Code* • Federal Office of Civil Rights investigates, substantiates allegation of HIPPA violation but *no fines or penalties* • Reports filed with Livonia and Detroit Police, *no charges*
Feb. 2010	• Womans Choice, Delta Twp. Lansing • Womans Choice, Saginaw	Owner: Richard and Maggie Remund	Remains of 17 babies in bags with mothers' full names, patient logs with over 500 patient names, medical records, bloody surgical material	• MI DEQ investigates, *no fines or penalties* • Attorney General investigates with Eaton and Saginaw County Sheriffs' Departments. A.G. files lawsuit to shut down both clinics for improper incorporation.

Two decades later, in 2008, abortion advocates discovered that six Detroit area abortion clinics were disposing of biohazard waste and patient records simply by dumping them in common trash receptacles. Alberto Hodari, the owner of the WomanCare Lansing clinic in the 1989 case, owned three of the six clinics, WomanCare of Southfield in Lathrup Village, WomanCare in Sterling Heights, and WomanCare of Downriver in Southgate. The three locations had bloody surgical material and a total of over 200 patient records in the trash. These patient records included photocopies of drivers' licenses, insurance forms, and lab reports. The Lathrup Village location also had the remains of 18 aborted babies in the trash.[4]

Two clinics owned by abortion doctor Reginald Sharpe, Women's Advisory Center in Livonia and Sharpe's Family Planning in Detroit, were also found to have bloody surgical material, numerous patient records at both locations, and the remains of 10 aborted babies at the Livonia location. The sixth clinic was Eastpointe Gynecology in Detroit, owned by abortion doctor Jacob Kalo. Forty to fifty patient records, used syringes and other used surgical materials were found.

Local, state and federal[5] enforcement confirmed violations of the law, but the response was weak. The Oakland County prosecutor's office charged Hodari's Lathrup Village location with 12 counts of improper disposal of medical records, and eventually dismissed charges on condition of payment of a $100 fine.[6]

MI Department of Environmental Quality investigations confirmed violations of the state's Medical Waste Regulatory Act at Reginald Sharpe's Livonia location and Alberto Hodari's Lathrup Village location. Violations included that the clinics did not even hold mandatory certification as medical waste producing facilities. Hodari was told to retrain staff. Neither Hodari nor Sharpe were fined, either for failure to hold certification or for the medical waste disposal violations.[7] In addition, the Michigan Bureau of Health Professions investigated both Hodari and Sharpe and determined that there was no violation of the Public Health Code.

Inadequate enforcement again failed to deter this common practice of illegal dumping in the abortion business. Two years later, in February 2010, a prolife activist found 17 aborted babies in the business dumpster outside the abortion clinic WomansChoice near Lansing. Investigations revealed that the owners were Richard and Maggie Remund, owners of the other clinic involved in the 1989 dumping discovery. The building housing the Remund's original abortion clinic,

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[4] Damron, Gina. "Clinic Broke Medical Waste Rules." *The Detroit Free Press.* March 26, 2008.
Kozlowski, Kim. "Biomedical Waste Found in Abortion Clinic Trash." *The Detroit News*. March 11, 2008.

[5] A prolife advocate filed complaints with the federal Office of Civil Rights, which enforces the privacy provisions of HIPPA (the Health Insurance Portability and Accountability Act). OCR confirmed improper disposal of patient health information at Sharpe's Family Planning, Women's Advisory Center, Eastpointe Gynecology and at least one Womancare location. They did not conduct any onsite visits, however. Two years after the complaints were filed, OCR closed the matter with a determination that all clinics in question had come into compliance voluntarily with federal HIPPA laws by sending OCR new policies and procedures regarding disposal of patient health information.

[6] Complaint and Order. *People of the State of Michigan v. WomanCare of Southfield, P.C.*

[7] Letter from MI DEQ addressed to Dr. Reginald Sharpe, dated May 16, 2008.
Kozlowski, Kim. "State Tells Abortion Clinic to Retrain Staff in Waste Disposal." *The Detroit News*. March 26, 2008.

Health Care Clinic, had been demolished, and the Remunds had opened WomansChoice on the west side of Lansing.

Just as in the 1989 incident, the containers with the aborted babies were labeled with the women's full names. The business dumpster also contained voluminous medical records, including patient logs with full names and insurance information, bloody surgical material, and used urine specimen cups labeled with the women's names.

A search of the Remund's sister clinic in Saginaw revealed more bloody surgical material and more medical records, including patient logs.[8] Between the two clinics, records with the names of over 500 abortion patients were obtained.

The Attorney General filed a lawsuit to shut down both clinics on November 7, 2011. The suit resulted from an investigation conducted by the A.G., and the Eaton and Saginaw County Sheriffs' Offices. The clinic owners, Richard and Maggie Remund, had incorporated the clinics illegally, without any licensed medical professional overseeing the clinics.

No state agency has assessed any penalties against the Remunds' clinics.

Section 2: Negligent Operative and Post-operative Practices

Documentation from state agencies and administrative courts reveal a pattern of negligent operative and post-operative practices among abortion clinics that result in patient injury and even death. Clinics routinely have insufficient recovery wards that lack basic monitoring and resuscitation equipment, fail to ensure adequate monitoring of patient recovery by licensed medical professionals, and perhaps most disturbing, refuse timely transport to a hospital when a patient needs emergency intervention.

Abortion clinic Womancare of Southfield has a documented history of patient endangerment through negligent post-operative procedures.

In 2003, patient Regina Johnson died of cardiac arrest following administration of general anesthesia for a first-trimester abortion at Womancare of Southfield. An expert review of the Bureau of Health Professions investigation of the death deemed recovery room conditions at WomanCare "woefully inadequate and substandard."[9] The Attorney General filed a suit against Milton Nathanson, who performed the abortion, Alberto Hodari, clinic owner, and the nurse anesthetist, Barry Thompson. The Complaint[10] alleged that all of the following led to Regina Johnson's death: (1) The patient recovery room was not equipped with oxygen or resuscitation equipment, (2) The patient recovery room was not equipped with standard monitoring equipment such as a pulse oximeter, (3) Only one nurse was monitoring 5-6 patients with no other clinic

[8] Bell, Dawson. "Law Called for after 17 Fetuses are Discovered." *Detroit Free Press*. October 28, 2010.

[9] Expert review conducted by Michael Hertz, M.D., who at the time was medical director of Planned Parenthood of South Central Michigan. In the Matter of Milton Nathanson, M.D., File No. 43-06-101294. Amended Opinion.

[10] In the Matter of A. Alberto Hodari, M.D., File No. 43-06-102963. Complaint.

staff available, when standard of care is one nurse for two patients, (4) Emergency Medical Services was not contacted until 20 minutes after the nurse detected no pulse.

Nearly six years later, in March 2009, the Board of Medicine found Hodari, Nathanson and Thompson to be negligent in Regina Johnson's death. All were fined, and the Board sent an anesthesiologist to inspect post-operative procedures and equipment at Womancare of Southfield and two other clinics owned by Alberto Hodari. He certified compliance with appropriate standard of care at the clinics.

However, just seven months later, in October 2009, a Bureau of Health Systems inspection of Womancare of Southfield revealed that the woefully sub-standard patient care which led to Regina Johnson's death had *not* been corrected. The Bureau of Health Systems cited Womancare for noncompliance with state surgical facility standards, including *no oxygen* available for patients at the facility,[11] no emergency call system,[12] and a recovery room with several deficiencies, including an insufficient number of beds to support patient caseload.[13] BHS licensure and enforcement actions with regard to Womancare of Southfield will be addressed in Part II.

Among the dozens of lawsuits filed against Womancare of Southfield is a September 20, 2010, suit brought by abortion patient Syndra Feetham,[14] who alleges in her Complaint a failure to secure emergency care for her in a timely manner before she was irreparably injured.

Documentation reveals similar patient endangerment at other abortion clinics as well, indicating a pattern of dangerous and negligent practices throughout the business.

A November 2007 Bureau of Health Systems relicensure survey at Birth Control Center, Inc., found no oxygen available for patients. At the time of the survey, this facility performed abortions up to 24 weeks, and used anesthetics that require oxygen to be on hand. [15] In addition, none of the 4 records that BHS reviewed contained a notation that the patient could be discharged safely, indicating that the clinic failed to have a physician on the premises during post-operative recovery.

One of the most egregious documented examples of grossly negligent post-operative practices occurred at Women's Advisory Center in Livonia, owned by Reginald Sharpe.

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[11] Michigan Department of Community Heath, Statement of Deficiencies, Womancare of Southfield, October 20, 2009. Pgs. 5-6.

[12] Pg. 5.

[13] Pg. 8.

[14] *Feetham, Syndra v. Roumell, Theodore, et.al*. 10-113534-NH (Oakland County Circuit Court 1992)

[15] The relicensure survey found an open Xylocaine vial in the operating room. The FDA has issued the following warning regarding Xylocaine use, a common nerve block used in abortion clinics: "Xylocaine injections...should be employed only by clinicians who are well versed in diagnosis and management of dose-related toxicity and other acute emergencies that might arise from the block employed and then only after ensuring the *immediate** availability of oxygen, other resuscitative drugs, cardiopulmonary equipment and the personnel needed for proper management of toxic reactions and related emergencies...Delay in proper management of dose-related toxicity, underventilation from any cause and/or altered sensitivity may lead to the development of acidosis, cardiac arrest, and, possibly, death." **Emphasis in the original*. Available at <http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/006488s074lbl.pdf>.

The Attorney General administrative lawsuit against Reginald Sharpe relates the sequence of events.[16] The two-day late-term procedure was performed by Sharpe and Rodolfo Finkelstein in 2005. The second day, Sharpe was completing the procedure without Finkelstein when he told the patient he was unable to access the fetus, and directed her to the "recovery room" to rest. Sharpe then left the clinic for three hours, with the patient in the recovery room unattended by any licensed medical professional.

The patient's late-term abortion was incomplete and she went into labor in the recovery room. The unlicensed staff in the recovery room *refused her repeated requests to call an ambulance* or have her mother, who was in the waiting room, come in to see her. After three hours of heavy bleeding, contractions, and pain, she screamed loudly enough for her mother to hear her from the waiting room. The mother demanded entry into the recovery room, where she found that her daughter was in labor. She asked the unlicensed staff to help deliver the baby, but they refused.

The mother helped her daughter deliver the stillborn baby, and immediately after asked the staff to call an ambulance. *Staff again refused to call an ambulance*. *The patient's mother called EMS on her cell phone. When EMS arrived, the center's doors were locked and staff refused them entry,* delaying their entry into the clinic for at least 8 minutes. Meanwhile, the still-absent Sharpe had called EMS and *demanded that EMS not take the patient to the hospital*, informing the parties that he was "only 5 minutes away." To avoid a confrontation with Sharpe, EMS drove to a parking lot one block away to check the patient's vitals. When the patient finally arrived at Botsford Hospital, ER staff stabilized her and assessed the stillborn baby to be 27 weeks gestation.

The Board of Osteopathic Medicine and Surgery found Sharpe negligent and incompetent, fined him $5,000, suspended his license 120 days, and placed him on a one-year probation.

Abortion clinic refusal to secure emergency care for patients is endemic. In 2008 at WomansChoice in Lansing, Ronald Nichols, M.D., was in the middle of an abortion complicated by a gross medical error regarding gestational age, according to an Attorney General suit against the doctor. When Nichols ascertained the true gestational age of the fetus to be 20 weeks, he stopped the procedure after he had already ruptured the fetal membranes. He advised the patient, who was bleeding from the vagina and in pain, to drive 80 miles to his Bloomfield Hills abortion clinic. When she refused, the clinic requested that she sign the following statement:

> "Patient [name] was advised on the importance of seeking immediate medical attention regarding this matter. Appointment has been set up with an experienced provider in this area of medicine who is agreeing to see her immediately. Patient insists she wants to go to the emergency room with less experienced providers. Risks and consequences of her decision discussed with patient which include infection, sepsis, bleeding, increased pain and/or death. Patient understands and accepts responsibility for her decision and will not hold Dr. Nichols, Women's Choice, its associates, or employees liable." [17]

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[16] In the Matter of Reginald D. Sharpe, D.O., File No. 51-05-98202.

[17] In the Matter of Ronald A. Nichols, M.D., File No. 43-08-109430. Complaint, Paragraph 13.

The patient drove home, still bleeding. Family took her to Ingham Regional, where she was admitted and staff confirmed rupture of fetal membranes. The 20.5 week baby expired in utero the next day.

The Board of Medicine found Nichols negligent and incompetent, fined him $10,000, and ordered him to complete 100 hours of community service.

In another case, the Board of Medicine found that abortion doctor Michael Roth had so little concern for patient safety that he was performing abortions in patients' homes. Two such "at-home" surgical abortions are described in the state's Administrative Complaint.[18] In 1998 and 1999, Roth performed two surgical abortions on a woman whom he claimed could not leave the house because she had agoraphobia. However, the woman had identified herself as a bartender. Roth received six months probation and a $15,000 fine for this and other violations of the Public Health Code. He also provided an assurance that he "will never perform a pregnancy termination procedure outside an approved clinic/hospital/office setting."[19] Roth completed the probationary period and still holds his medical license.

Section 3: Refusal to Release Patient Medical Records

With dangerous operative and post-operative practices, it is little wonder that abortion clinics also routinely refuse to release patient medical records, either to a hospital providing care after an abortion complication, or directly to a patient per her request.

In the administrative lawsuit against Ronald Nichols, the Attorney General's Complaint alleges that the abortion clinic WomansChoice in Lansing repeatedly refused to release medical records regarding the patient to the hospital that was providing emergency care after her botched abortion. Paragraph 17 of the Complaint reads:

> "IMRC [Ingham Regional Medical Center] made several attempts to obtain the Clinic's chart to facilitate B.R.'s treatment. However, the clinic refused to release the records until an attorney intervened on B.R's behalf after she was discharged. When B.R. went to retrieve them, Clinic personnel told her they had not released the records for fear they could end up "in the wrong hands."[20]

Staff at organizations that counsel women after abortions report that their clients often are unable to access their own medical records from abortion clinics. Clinics routinely turn away women who request their medical records, telling the women that the records are unavailable. Without access to an attorney, many women never obtain their own medical records.

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[18] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00, Administrative Complaint, Paragraphs 11-16.

[19] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00. Consent Order and Stipulation, Pg. 5.

[20] In the Matter of Ronald A. Nichols, M.D., File No. 43-08-109430. Complaint.

Section 4: Failure to Report Abortion Complications and Deaths

Abortion clinics also fail to notify the state of complications and patient deaths, as required by state law. Evidence of the failure to report complications include unrealistically low complication rates, and known instances of complications, including patient deaths, that never appeared in MDCH yearly reports of the abortion data submitted by physicians.

Michigan's abortion reporting law, enacted in 1978 (MCL 333.2835), mandates that physicians who perform abortions report all abortions to the state within 7 days, and include any immediate complications. A 1999 amendment to the law requires any treating physician to report subsequent complications, whether the treating physician is the same physician who performed the abortion, or another physician providing follow-up care such as an emergency room doctor or a private-practice OB/Gyn.

Michigan's complication rate for abortions before 21 weeks is .05-.09% for the years 2000-2009. The rate is less than 1% in most years for post-20 week abortions.

This rate is more than 10 times lower than Canadian abortion complication rates. The complication rate for over 36,000 abortions performed in Canadian hospitals in 2004 was 1.4% for abortions through 12 weeks gestation, and 10.7% for abortions at 21 weeks or greater. The Canadian data is very reliable because 100% of hospitals report abortion data to the Canadian government. All hospital abortions are government funded, providing incentive for the government to track accurately abortions and abortion complications in hospitals.

It is impossible that Canadian abortions performed in hospitals could be more than 10 times riskier than Michigan abortions performed primarily in "physician's private office" abortion clinics.

Physicians simply are not reporting complications. Several well-documented instances of abortion injuries and even deaths have not appeared on MDCH compiled reports of abortion data submitted by physicians.

- In 2004, 15 year-old Tamia Russell died of uterine sepsis within 24 hours of obtaining a late-term abortion at Dr. Alberto Hodari's WomanCare of Southfield. The Wayne County medical examiner confirmed that the sepsis was due to her abortion at six months gestation. The 2004 MDCH abortion report lists no deaths from abortion.

- The 2003 death of Regina Johnson, who never regained consciousness following her first-trimester abortion, was never reported. The Board of Medicine sanctioned the medical licenses of both physicians involved, Milton Nathanson and Alberto Hodari, as well as both nurses. However, the 2003 MDCH report lists no deaths from abortion.

- The 2005 late-term abortion performed by Dr. Reginald Sharpe at Women's Advisory Center in which Sharpe left the patient unattended and she delivered a stillborn baby was never reported, though the woman required extensive follow-up treatment at Botsford

Hospital. The 2005 MDCH abortion report lists no complications from abortions performed at private physicians' offices.

This failure to report complications renders the state unable to assess the risks for the woman undergoing an abortion in Michigan, and unable to identify those physicians and medical facilities that routinely jeopardize women's lives.

Section 5: Illegal Storage and Administration of Controlled Substances

Abortion clinics have a documented history of illegal drug storage and administration practices. These practices endanger patients, clinic staff, and the public.

In 1999, the Michigan Boards of Medicine and Osteopathic Medicine and Surgery found that it was "standard procedure" for unlicensed clinic personnel to administer Valium and Stadol to patients at WomansChoice abortion clinic in Lansing. These unlicensed staff members had access to Valium pills and Stadol injectables, an addictive opiate administered via intravenous and intramuscular shots. They routinely decided whether to give women these controlled substances prior to abortions, accessed the controlled substances, and administered them to patients, all with no oversight from a licensed medical professional.

Lewis Twigg, M.D., who had been performing abortions at WomansChoice at least since 1990, was reprimanded, fined $1000, and placed on a 30-day probation for allowing unlicensed staff to administer Valium. Twigg testified in the administrative court proceedings that "I followed in the footsteps of what was practiced for many years, allowing non-nurses to pass a medicine."[21]

Reginald Sharpe, D.O., also performed abortions at WomansChoice. The Board of Osteopathic Medicine and Surgery fined him $2,500 and gave him a probationary period of one year. It is unclear whether action was taken against any other individuals involved.

Improper drug prescribing, administration and storage are not isolated incidents, but rather established practice at many abortion clinics, as these additional examples reveal.

In 2002, abortion doctor Michael Roth's medical office was inspected by a state pharmacy investigator.[22] Roth was disciplined for the following drug-related violations:

- Dispensing of controlled substances even though Roth's license to dispense such drugs had expired more than 20 years prior
- Multiple years of prescribing controlled substances to patients without any justification documented in patient charts
- The discovery by the pharmacy investigator of 200-300 unsealed packets of misbranded, mislabeled controlled substances in a cabinet to which staff had access
- No inventory of drugs was being maintained at Roth's office

[21] In the Matter of Lewis H. Twigg, Jr., M.D., File No. 43-98-0337-00, Docket No. 1999-3055. Board of Medicine Disciplinary Subcommittee Findings of Fact and Conclusions of Law, Pg. 4.

[22] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00, Administrative Complaint, Paragraphs 36-41.

- A medical assistant dispensed controlled substances to Roth's patients when he was not present in the office, in violation of the Public Health Code due to the types of medication dispensed.

Abortion clinics that are licensed as freestanding surgical facilities engage in the same illegal practices. From 2007-2009, the Bureau of Health Systems inspected three abortion clinics licensed as freestanding surgical facilities: Birth Control Center, Inc. in Sterling Heights, Feminine Health Care of Flint, and Womancare of Southfield. All three were cited for noncompliance with state regulations for surgical facilities regarding the administration and/or storage of medication:

Violations at Womancare of Southfield, owned by Alberto Hodari, were particularly egregious. During an October 2009 investigation of Womancare, BHS staff found no physician's order for a medication that had been sent home with a patient, and no physician signature verifying several other medication orders. [23] They also found two unlocked hallway cupboards with multiple medications and an unsecured refrigerator with medications in patient areas where patients are left unattended. [24] Opened, unsecured medications included Ketamine, an addictive controlled substance often sold illegally as a "club drug" and used as a date-rape drug.[25] Narcotics logs were insufficient or nonexistent. BHS further learned that the facility had no policy for medication storage or for verifying which staff is licensed and qualified to administer medications. BHS cited the facility and accepted a plan submitted by Womancare to correct this noncompliance. BHS never returned to the facility to verify compliance, and does not appear to have referred the physicians overseeing the staff for disciplinary action by the Board of Medicine.

It is telling that all three clinics inspected by BHS were cited for noncompliance in this area, though the investigations were not triggered by complaints regarding medication storage or administration. Two were surveys for relicensure as surgical facilities and one was an investigation responding to an unrelated complaint.

Abortion clinic noncompliance with drug storage and administration regulations endangers the public health in multiple ways: (1) Unlicensed, unqualified personnel are making medication prescribing decisions, with no certified knowledge of correct dosage, allergic reactions and side effects, and drug interactions. (2) These unlicensed personnel are themselves administering highly toxic controlled substances to patients, both orally and by injection, a serious threat to patient health. (3) Noncompliance with storage and narcotics log regulations mean that clinic staff have easy access to highly addictive controlled substances, either for their own use or to give or sell to others. (4) Anyone coming in to the clinic has access to controlled substances.

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[23] Michigan Department of Community Heath, Statement of Deficiencies, Womancare of Southfield, October 20, 2009, Pgs. 10-12.

[24] Michigan Department of Community Heath, Statement of Deficiencies, Womancare of Southfield, October 20, 2009, Pgs. 7-8.

[25] U.S. Drug Enforcement Administration. "Ketamine." Available at http://www.justice.gov/dea/concern/ketamine_factsheet.html.

Section 6: Unsterile, Unsanitary Surgical Equipment and Environment

Another disturbing pattern among abortion clinics is the failure to ensure sterile surgical equipment and a sterile surgical environment. As noted in Section 5, the Bureau of Health Systems conducted only 3 onsite surveys of abortion clinics from 2007-2009. BHS cited all three for noncompliance with state surgical facility requirements regarding equipment sterilization, maintenance of a sterile environment, and sterile pre-op handwashing.

At Birth Control Center, Inc. in Sterling Heights, the doctor performing abortions had no pre-operative scrub sink, but rather the physician, Richard Goldfine, scrubbed up for procedures in the same hand wash sink "also used to separate solid waste products from liquids collected during or after the procedure."[26] The physician was actually washing his hands over an unsterile strainer and unsterile equipment used to empty and process waste and fetal remains after abortions. In addition, the facility was storing clean instruments in the same room in which dirty, used equipment was being sterilized. The clinic was doing nothing to ensure that equipment used in procedures actually was sterile. BHS cited them for failure to conduct any spore tests, when weekly tests are the standard for health facilities.

Womancare of Southfield also failed to have a scrub sink for surgery. During their first visit, BHS noted:

> "It was observed that the Physician/owner [Alberto Hodari] washed his hands in the dirty utility room, over the dirty instruments sitting in the sink. He proceeded to turn off the faucet; opened up the bottom of a cupboard, he reached down under the counter and then grabbed the top towel from the stack of unfolded hand towels. He dried his hands in the dirty utility room placed the used towel on the counter and then proceeded to open the door to the operative/treatment room."[27]

BHS also cited Womancare of Southfield for no handwashing/scrub policy for medical staff, no written procedure for sterilizing and reprocessing surgical equipment, and an operating table with a ripped cover, rendering it uncleanable/unsterile.

At Feminine Health Care in Flint, again clean instruments were being stored in the same space in which dirty instruments were sterilized, and the clinic also was not conducting weekly spore tests to check equipment safety. In addition, the clinic failed to have a sanitary liquid waste disposal system.

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[26] Michigan Department of Community Heath, Statement of Deficiencies, Birth Control Center, Inc., November 08, 2007, Pg. 3.

[27] Michigan Department of Community Heath, Statement of Deficiencies, Womancare of Southfield, October 20, 2009, Pgs. 11-12.

Section 7: Violation of Informed Consent Law and Forced Abortions

Documentation shows that abortion clinics also routinely violate Michigan's 1993 informed consent law. Even more disturbing, abortion patients have made allegations that not only did the abortion doctors not follow informed consent procedures, but the doctors actually forced unwanted abortions upon them.

The law requires that women be given standard information created by the state about fetal development, and abortion procedures and risks 24 hours prior to the abortion. The woman must sign informed consent documentation that she has read the materials and understands the risks.

In 2004, the Board of Medicine found that abortion doctor Michael Roth had violated the informed consent law in at least two instances. The patient did not receive any of the required information, and there were no signed consent forms for the abortion procedures.[28] A clinic staff member stated that in addition to these two incidents, she witnessed "24 hour consent forms being predated on a regular basis" so that the abortion could be performed that day, or a late-term, two-day procedure could be started that day. Roth received patients for late-term abortions from various Michigan clinics and a Toronto, Canada, clinic that all faxed to Roth's office pre-dated informed consent documentation.[29]

In May 2006, an allegation was filed against abortion doctor Robert Alexander with the Bureau of Health Professions, alleging violations of Michigan's informed consent law, among other abuses. The allegation included a document that a prolife individual had obtained outside of Alexander's WomansChoice abortion clinic. The handwritten document was given to patients along with the required informed consent materials that explain fetal development and abortion procedures.

The document states: "The State of Michigan Informed Consent Papers * You need these papers 24 hours before you [sic] appt. * It's your choice to read these papers or not. Thank you, WomansChoice."[30]

This document indicates that the abortion clinic tells women they do not have to read the state-mandated informed consent materials, the very materials that provide information about the procedures the women are about to undergo and the risks associated with those procedures. The Board of Medicine did not authorize this allegation for investigation, so unfortunately no further information is available regarding this disturbing practice. This case will be discussed further in Part III, Section 8.

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[28] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00, Administrative Complaint, Filed October 16, 2003. Paragraphs 11-15.

[29] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00. Original Allegation, and State of Michigan Office of Health Services interview of Janice Kirkland. Statement of Janice Kirkland. Pgs. 2-3.

[30] Allegation filed with the Bureau of Health Professions, May 18, 2006, File No. 43-06-101901. Affidavit obtained by RLM.

Even more disturbing, several instances of alleged forced abortion have emerged. These women allege that abortion practitioners continued the abortion procedure, even after they told the practitioner to stop, or in one case, tried to get up off the procedure table.

Two women filed allegations against abortion doctor Alberto Hodari with the Bureau of Health Professions, one for a 2009 incident at Feminine Health Care in Flint, and the other in 2008 at Womancare of Southfield. In both instances, the patients allege that Alberto Hodari and/or an assistant used force to hold her down while the abortion was performed.

In the 2008 incident, the patient alleged that she received no local anesthesia and therefore tried to stop the procedure due to her extreme pain. Doctor notes from Troy Beaumont, where she was hospitalized for three days following the abortion, read as follows: "[Patient] states screamed and thrashed, even tried to wiggle up bed [sic] r/t severe pain. States physician pulled her back down by her thighs and his female assistant 'put her hand over my mouth.'"[31]

In the 2009 incident, the patient alleges that Alberto Hodari performed the procedure even though she told him repeatedly to stop, even screaming for him to stop. Similar to the 2008 incident, the doctor ordered an assistant to hold the patient down and cover her mouth. This patient filed a lawsuit[32] in addition to her Bureau of Health Professions allegation. The lawsuit settled out of court.

Another allegation of an abortion performed after the woman told the physician to stop the procedure was filed in 2011 against Michael Hertz, M.D., at his abortion practice Northland Family Planning in Sterling Heights.

The Board of Medicine did not authorize any of these three allegations for investigation. These incidents will be discussed further in Part III, Section 6.

Section 8: Abortions Past the Point of Viability

Abortion clinics also perform abortions past the point of viability without documentation of a maternal health reason. Abortion doctors have even falsified medical records to give the appearance that the baby was pre-viable, when in fact the baby would have survived outside the womb.

Abortions are legal in Michigan through the ninth month of pregnancy. However, if the fetus is near the point of viability outside the womb, the doctor must ascertain viability. If the baby is viable, the doctor must assert a maternal health reason for the abortion. Babies at 24 weeks gestation dated from the last menstrual period, about 22 weeks from conception, have about a 50% long-term survival rate outside the womb.

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[31] Allegation filed with the Bureau of Health Professions, August 18, 2008, File No. 43-08-109481. Hospital records obtained by RLM.

[32] *Bruce, Caitlin, v. Hodari, Abraham, et. al*. 09-91456-NH. (Genesee County Circuit Court 2009).

Two late-term abortions performed by Michigan doctor Gilberto Higuera in 1993 and 1994 are the best-known documented instances of performance of an abortion on a viable baby without documentation of a maternal health reason. Higuera performed the abortions at his Highland Park abortion clinic in November 1993 and October 1994.

According to the Complaint in the administrative lawsuit with the Board of Medicine,[33] Higuera performed the first abortion on a fetus that was 27 weeks old, as confirmed by ultrasound. No maternal health reason was indicated. The second abortion was originally documented in the patient's chart as an abortion at 28 weeks gestation. Higuera then falsified the patient's chart, replacing the 28 week notation with a notation of 24 weeks. The Board of Medicine suspended Higuera's license.

In addition to the Board of Medicine legal action, the state brought criminal felony charges against Higuera[34] both for performance of abortion on a viable fetus without a maternal health reason, and for falsification of medical records. The patient who had the October 1994 abortion testified that she had no health reason for seeking the abortion, for which Higuera charged her $3,000. After performing the first stage of the two-day procedure, Higuera instructed the patient that if she went into labor overnight she should not to go to the hospital or call 911 because "they" would deliver a live baby. The patient testified that she was shocked to learn that the baby was viable. A former clinic employee testified that the abortion clinic routinely aborted babies past 24 weeks gestation.

After lengthy appeals, Higuera pled guilty in 2001 to the felony charge of falsifying medical records. As part of the plea bargain, the state dropped the felony charge of performance of abortion on a viable fetus without a maternal health reason. Higuera then moved out of state.

More recent examples of abortions at or beyond 24 weeks gestation show gross incompetence in ascertaining gestational age at the very least, and at worst, willful dishonesty on the part of abortion doctors in order to perform (and charge for) late-term abortions without a maternal health reason.

One such example is the 2005 late-term abortion performed by Rodolfo Finkelstein and Reginald Sharpe at Women's Advisory Center in Livonia, during which Sharpe left the patient unattended for three hours and she delivered a stillborn baby in the recovery room. The case was detailed in Section 2. In that instance, Finkelstein first performed an ultrasound and told the woman she was at 23.5 weeks and would have to undergo the abortion immediately.[35] Finkelstein had obtained his Michigan M.D. license in 1980 and had been performing abortions for decades at the time this incident occurred. Finkelstein then performed the first stage of the two-day procedure. The next day, Sharpe took over for Finkelstein, had difficulty completing the abortion due to the advanced gestational age, and left the clinic with the procedure incomplete. The woman went into labor in the recovery room and delivered a stillborn baby with only her mother assisting her. Botsford Hospital assessed the fetus at 27 weeks gestation, three and a half weeks later than

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33 In the Matter of Jose Gilberto Higuera, M.D., Complaint No. 43-94-5210-00.

34 *The People of the State of Michigan v. Jose Gilberto Higuera*. Complaint No. 96-96-000046-01.

35 In the Matter of Reginald D. Sharpe, D.O., File No. 51-05-98202. Complaint, Paragraph 8.

Finkelstein's assessment after ultrasound. The Board of Medicine revoked Finkelstein's license in October 2005.

During the 2004 Board of Medicine disciplinary case against Michael Roth, a former office employee stated that Roth was performing abortions past 24 weeks and falsifying medical records that indicated gestational age.[36] She stated that these women came as referrals from other abortion clinics in Southfield and Novi, and the Morgantaler abortion clinic in Canada. The Canadian government would pay $2,500 for the abortion to be performed in the U.S., according to the former employee.

The former employee stated that Roth would perform abortions at 26 weeks or more. She normally did the pre-abortion ultrasounds in the office, but when one of these women would come in for an abortion, Roth performed the ultrasound himself so that he could manipulate the machine and generate a record that showed fewer weeks gestation than was actually the case.

In one instance, the Toronto Morgantaler Clinic faxed Roth's office the medical record of a woman seeking an abortion. Roth reviewed the record and told the staff member that he would not perform the abortion because the woman was past 25 weeks. However, shortly thereafter Roth had a phone conversation in his office with the Toronto clinic. When he emerged from his office he told staff that the woman was coming in shortly for the abortion. She arrived that day, and Roth performed the ultrasound, then began the two-day procedure by inserting laminaria to open the cervix. The woman stayed overnight at the Red Roof Inn in Farmington Hills. For the second day of the procedure, the former employee assisted by providing ultrasound guidance. The procedure was a partial-birth abortion, which the former employee described in detail to the investigator.[37]

It appears that the state's investigation of Roth was complicated by difficulty in locating former patients, and unwillingness on the part of patients that they located to participate in the investigation. The state did not obtain further information on the falsification of gestational ages and abortions past the point of viability. However, Roth was disciplined for multiple other violations in the 2004 Board of Medicine case, including failure to document information such as patient age and vital statistics in charts, violations of the informed consent law, performance of abortions in patients' homes, and unlawful storage and dispensing of controlled substances.

More recently, in June 2009, a Grand Rapids OB/Gyn filed an allegation against abortion doctor Robert Alexander, alleging gross negligence in attempting an abortion on a woman who was 26 weeks pregnant.[38] The OB/Gyn was providing medical care for the woman after she came into the hospital emergency room, still pregnant. When the OB/Gyn followed up with Alexander, Alexander informed him by phone that he had done a "limited ultrasound," but it was difficult to perform the ultrasound due to the patients' obesity. The OB/Gyn states in the allegation that no

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[36] In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00. Original Allegation, and State of Michigan Office of Health Services interview of Janice Kirkland. Statement of Janice Kirkland.

[37] The employee quit in 2000, so partial-birth abortions in which she assisted would have been performed prior to the 2003 federal ban of partial-birth abortion, the 2007 U.S. Supreme Court decision upholding the federal ban, and the enactment of Michigan's state ban in 2011.

[38] Allegation filed by unknown OB/Gyn with the Bureau of Health Professions, June 12, 2009, File No. 43-112676.

matter how obese the patient, the physician "should have visualized a viable intrauterine pregnancy." The patient told the OB/Gyn that Alexander's office had called her multiple times, offering her a refund of the abortion fee, plus $200. The woman did not accept this offer and retained an attorney. The Board of Medicine did not authorize this allegation for investigation by the Bureau of Health Professions, and this case will be discussed in more detail in Part III.

Part I Conclusion

The grim history of the abortion business in Michigan reveals a pattern of gross noncompliance with health and safety regulations, state law, and professional standards of conduct.

These practices have become entrenched in the industry in the absence of any meaningful state enforcement. Part II details the Bureau of Health Systems' failure to ensure licensure of clinics and minimum health and safety standards. Part III reveals failures on the part of the Bureau of Health Professions and medical licensing boards to discipline and remove unsafe medical professionals.

Part II: Bureau of Health Systems Fails to Regulate Abortion Clinics

This part details systematic failures by the Bureau of Health Systems to ensure that abortion clinics are licensed and operating according to state surgical facility standards. Though state law requires that abortion clinics hold state licensure as surgical outpatient facilities, *only 4 of the 32 surgical abortion facilities are licensed as freestanding surgical outpatient facilities*. For decades the Bureau of Health Systems has ignored reports of facilities operating without licensure. BHS routinely fails to ensure that the few licensed facilities actually meet health and safety requirements due to woefully inadequate pre-licensure practices, failure to conduct state-mandated annual visits, and lack of consistent action against clinics that inform BHS they no longer "want" their statutorily required licensure.

Sections 1-7 cover the following regarding BHS oversight of the abortion industry:

- Structure and duties of BHS,
- State law mandating the licensure of abortion clinics, and the health and safety standards for licensed surgical facilities,
- Historical overview of four decades of abortion clinic resistance to state licensing, and state administrative failure to compel licensure,
- BHS's failure to follow their own licensure procedure for surgical facilities, resulting in grossly deficient abortion clinics obtaining state licensure,
- BHS's questionable waiver policy that permits abortion clinics specifically to waive many FSOF requirements,
- BHS's failure to conduct statutorily mandated annual visits to surgical facilities at least for the last decade,
- Inconsistencies regarding BHS response to abortion clinics that inform BHS that they no longer "want" FSOF licensure, then operate illegally without the mandatory license.

Section 1: Bureau of Health Systems Structure and Duties

The Bureau of Health Systems within the Department of Licensing and Regulatory Affairs (LARA) is charged with protecting the public health by ensuring that medical facilities meet minimum state health and safety standards. BHS licenses medical facilities, and investigates consumer complaints against medical facilities. In addition to licensing and monitoring abortion clinics and other surgical facilities, they also have jurisdiction over most other types of medical facilities: hospitals, nursing homes, home health agencies, hospices, certain psychiatric programs, laboratories, kidney disease facilities, county medical facilities, and rural health clinics.

The Bureau consists of the central Bureau Office and four Divisions: Health Facilities & Services, Licensing & Certification, Nursing Home Monitoring, and Operations.

The Division of Licensing and Certification licenses hospitals, surgical facilities, and other "non long term care" facilities. They also investigate complaints against these facilities, which would include complaints against abortion clinics. Licensing and Certification is also responsible for scheduling regulatory visits to these facilities, though the BHS is woefully noncompliant with state law mandating annual visits, as explained in Section 6.

The Division of Operations contains the Complaint Investigation Unit, which receives consumer complaints about all health facilities. Complaints about nursing homes are investigated within this division, and others are referred.

The Division of Health Facilities and Services reviews proposed health facility design plans and issues construction permits. They are charged with identifying and resolving construction and design-related problems in health facilities, which include environmental and infection control problems.

The Division of Nursing Home Monitoring annually inspects nursing homes and long-term care facilities. They do not have any involvement with surgical facilities.

Section 2: Requirements for Surgical Facility Licensure

In 1999, the legislature enacted PA 206 requiring that abortion clinics in which more than 50% of their patients receive an abortion obtain state licensure as "freestanding surgical outpatient facilities," or FSOFs (MCL 333.20115).

FSOFs are medical facilities in which outpatient surgery is performed routinely. Other health facilities with FSOF designation include hospital-affiliated outpatient surgery centers, hemorrhoid removal clinics, and facilities performing endoscopic procedures.

MCL 333.20821 establishes the requirements for FSOFs. They must have the medical and supportive personnel, as well as the necessary equipment, to perform safely the surgical procedures and provide related care. They must have a written agreement with a "nearby" hospital for admission of patients following complications. They must establish a clinical record for each patient that includes a history, physical exam, justification for treatment, tests and examinations, observations made and treatment provided.

LARA administrative rules 325.3822-3877 clarify statutory requirements and add additional requirements for licensure. Following is a partial list:

- Disaster and emergency procedures (R 325.3822)
- A qualified physician must be present throughout the post-operative period (R 325.3826(2))
- Informed consent provisions must be observed, and the abortion informed consent law (MCL 333.17015) is cited specifically for abortion clinics (R 325.3828)
- Records must be kept that include, at a minimum, all surgical procedures performed each day, a monthly summary of surgical procedures, a narcotics log, and transfers to a hospital post-surgery with case outcomes (R 325.3831)

- The facility must be within 30 minutes normal driving time of a hospital with which written admission arrangements have been made (R 325.3832)
- Appropriate counseling prior to "procedures having present or future social implications for a patient...such as human sterilizations and pregnancy terminations." This counseling must be free from coercion. (R 325.3833)
- A written policy for scrub procedures (R 325.3839)
- Detailed requirements for creating and maintaining individual patient records (R 325.3847) and storing the records (R 325.3848)
- Clinical facilities requirements, including minimum room size, clearance for a stretcher, a nurse call system, handwashing facilities, sterilization equipment, and other requirements. Abortion clinics can waive this administrative rule (R 325.3866), pursuant to subsection 13 of the rule.
- Medication storage and other storage areas. Abortion clinics can waive this administrative rule (R 325.3867), pursuant to subsection 7 of the rule.
- Patient observation and recovery areas that can accommodate a three-hour recovery period, with minimum floor and entryway space requirements. Abortion clinics can waive this administrative rule (R 325.3868), pursuant to subsection 9 of the rule.

Facilities also must comply with the state Life Safety Code, which addresses safety from fire and other hazards, and MDCH's design and construction standards for health facilities in Michigan.[39] These requirements mandate maintenance of a sanitary environment, certain design specifications, emergency admission arrangements with a nearby hospital, and appropriate waste disposal in accordance with the Medical Waste Regulatory Act.

The requirements for freestanding outpatient surgical facilities are intended to ensure minimum health and safety requirements for facilities that perform surgeries not requiring an overnight hospital stay. However, the great majority of abortion clinics operate without the statutorily required licensure, and have resisted licensure efforts for decades, as explained in the next section.

Section 3: Abortion Clinic Resistance to Licensing: Historical Overview and Current Situation

Currently only 4 of the 32 abortion clinics in Michigan hold valid FSOF licensure. The four licensed clinics are Planned Parenthood of Mid-Michigan (Ann Arbor facility), Planned Parenthood of South Central Michigan (Kalamazoo facility), Feminine Health Care Clinic of Flint (one of Alberto Hodari's clinics), and Heritage Clinic in Grand Rapids.

All of the remaining 28 clinics meet the 50% threshold, with the possible exception of a new Flint Planned Parenthood location. These clinics advertise abortion through the Internet, phone

[39] Available on MDCH website at <http://www.michigan.gov/documents/mdch/bhs_2007_Minimum_Design_Standards_Final_PDF_Doc._198958_7.pdf>.

book, and other means. They are known in their communities as abortion clinics, and many have been in operation at the same location since the 1970s. With the exception of the Flint Planned Parenthood clinic, women visit these facilities exclusively to procure abortions.

The struggle to ensure abortion clinic compliance with minimum health and safety requirements has spanned four decades. In 1974, one year after Roe v. Wade declared abortion a constitutional right, a *Detroit Free Press* exposé of ten Michigan abortion clinics revealed serious endangerment of patients' safety and health. Five of the ten clinics told undercover *Free Press* reporter Dolly Katz that she was pregnant following urine tests and tried to schedule her for an abortion, though Ms. Katz was not pregnant.[40] Other reports of unsafe and unscrupulous practices at abortion clinics surfaced, and the public called for regulation.

In 1978, the legislature enacted P.A. 368, which defined freestanding outpatient facilities and established the licensing requirements for FSOFs, which are covered in the previous section. The Michigan Health Department actively sought out abortion clinics and facilities performing other outpatient surgeries to compel licensure as FSOFs. They looked for abortion clinics in phone book listings, accepted tips from journalists, and conducted multiple visits to abortion clinics and other facilities. Abortion clinics fought the licensure efforts. By mid-1980, only 11 of the 30 abortion clinics that the state had identified were licensed.

In January 1980, Attorney General Kelley filed a lawsuit to close four abortion clinics that had resisted licensure. In early February, several abortion clinics and abortionists brought a lawsuit against the Michigan Department of Health (*Birth Control Centers, Inc. v. Reizen*), alleging that the 1978 law was unconstitutional, and the Department of Health was enforcing the law selectively by targeting abortion clinics. The Department of Health then suspended efforts to compel licensure of abortion clinics as the case was litigated and appealed.

In 1984, The U.S. Court of Appeals ruled that regulation of abortion clinics as freestanding surgical outpatient facilities was constitutionally permissible and the state was not discriminatorily targeting abortion clinics in their enforcement efforts. However, they found many of the specific regulations to be unconstitutional state infringement on the right to abortion. Efforts to compel abortion clinics to follow health and safety standards were over for the time being.

Subsequent federal court decisions in the late 1980s and 1990s lowered the standard of review for state regulation of abortion, opening the way for increased regulation. This change in standard for determining what state regulations would be considered constitutional enabled the Michigan legislature to enact P.A. 206 of 1999, the 50% rule.

Enforcement efforts were weak, unlike Department of Health enforcement attempts from 1978-1980. MDCH abortion reporting data indicated 31 nonlicensed locations that performed abortions, and the Department sent letters to these locations informing them of the 50% rule. Clinic compliance was voluntary. A few clinics chose to be licensed, and there was no Department follow-up with those that did not.

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[40] Betzold, Michael. "License Crackdown Stirs Abortion Clinic Fight," *Health Care News*. February 6, 1980.

The bias against enforcement persists. In the last decade, BHS has refused to investigate abortion clinics operating without FSOF licensure, maintaining that such facilities are private physicians' offices and do not fall under BHS jurisdiction. In April of 2011, RLM asked BHS what the Bureau could do about a health facility that required licensure, but was operating without a license. BHS told RLM to contact the Attorney General's office, and did not provide any further assistance.[41]

Citizens have made complaints to the Bureau of Health Professions about individual physicians unlawfully operating unlicensed abortion clinics. The Bureau of Health Professions is charged with investigating and disciplining licensed health professionals, as discussed in Part III. The Bureau of Health Professions and the Michigan Board of Medicine have ignored those allegations.

More than 30 years after the people of Michigan attempted to impose minimum health and safety standards on abortion clinics, nearly 90% of clinics are still unlicensed and unregulated.

Section 4: Haphazard Licensing Procedure Grants Licenses to Dangerous Facilities

For the few clinics that do seek licensure, BHS files reveal haphazard licensing procedures that put the public's health in jeopardy. In fact, *BHS has granted FSOF licenses without ever setting foot in the facility*.

LARA administrative rule 325.3812 states that the department shall issue a license "If the department determines that a facility complies with the act and these rules." BHS fails to comply with this administrative rule.

Licensing Division Director Larry Horvath provided to RLM the Bureau's protocol for licensing surgical facilities, and admitted that BHS has not followed this protocol consistently.

The protocol begins with a "desk audit" by the Engineering Section of BHS to review architectural plans for compliance with FSOF physical structure requirements. This review of plans is done both for existing buildings and for proposed buildings.

If the plans do not comply with FSOF structure requirements, then the facility owners may request waivers of some of these requirements. Abortion clinics and other health facilities may only request waivers at this point in the process, in accordance with LARA administrative rule 325.3868a(2), which states: "A pregnancy termination facility shall submit a request for [a waiver] in writing at the time of application for a license." According to Horvath, waivers are granted "sparingly," as the "spirit and intent of the code is to protect the patient."

[41] New Licensing Division Director Larry Horvath said that going forward, BHS would take these complaints seriously and make a referral to the Attorney General. Furthermore, he plans to have a protocol in place by 2012 to make annual visits to medical facilities that are not licensed, to monitor whether they do in fact fall below licensing thresholds.

After the waiver process, BHS conducts an inspection onsite to determine compliance with non-structural regulations, such as medical office procedures and equipment. BHS creates an "Opening Survey" with BHS findings from both the desk audit and the onsite inspection. If the facility meets all requirements, then the license is issued.

The BHS file on Alberto Hodari's WomanCare of Southfield abortion clinic illustrates the bureau's woeful departure from this licensing procedure. In this case, BHS put a state stamp of approval on a dangerous medical facility that never should have received a license.

WomanCare of Southfield has been operating in its present location since 1975. It is owned by Dr. Alberto Hodari, who has owned up to 5 additional abortion clinics simultaneously in the past.

WomanCare was never licensed as an FSOF until the fall of 2008. According to a 2011 Attorney General lawsuit against WomanCare, Hodari sought licensure at this time because "a MDCH audit revealed it was unlawfully providing surgical and related care to more than 50% of its patients on an annual basis without an FSOF license."[42] BHS does not have a record of an audit or any type of visit to this facility at this time, indicating that the audit was done through a different department. A FOIA request did not reveal the nature of the audit, though possibly it was a Michigan Department of Environmental Quality investigation of the 2008 illegal dumping of biomedical waste and patient records, as recounted in Part I, Section 1.

BHS granted WomanCare an FSOF license in December 2008 without visiting the facility or conducting any kind of evaluation to determine the facility's compliance with FSOF regulations. There was no desk audit by the Engineering Section, or onsite inspection to verify compliance. There was no Opening Survey.

In fact, the application appears to have been "fast-tracked." BHS actually mailed WomanCare an invoice for the licensing fee before the owner even submitted WomanCare's FSOF application to BHS. The invoice was mailed September 17, 2008, and the application was received September 29, 2008. A handwritten note on the application indicates that the license fee was paid that same day, September 29.

In October of 2009, a year after issuing the license, BHS visited WomanCare. This visit was pursuant to a complaint of unknown nature. The file indicates no intention on the part of BHS to conduct any kind of licensure follow-up inspection.

The October 2009 visit revealed over 40 instances of noncompliance with FSOF regulations, including expired medication and open medication stored in unlocked cupboards, no handwashing protocol for staff, unsanitary operating table pads, preoperative handwashing being done in a dirty sink used to process and dispose of waste, no oxygen for patients, and no emergency nurse call system.

The last two violations are significant, as they resulted in the 2003 death of abortion patient Regina Johnson, as explained in Part I, Section 2. At the time that BHS granted FSOF licensure,

[42] *Attorney General Bill Schuette v. Womancare of Southfield, P.C., et.al.* (Oakland County Circuit Court 2011).

the Michigan Board of Medicine and the Bureau of Health Professions were in the process of taking disciplinary action against Alberto Hodari as owner of WomanCare, and Milton Nathanson, M.D., who performed the abortion on Ms. Johnson.

Regina Johnson had died of cardiac arrest following administration of general anesthesia for a first-trimester abortion in 2003. The Bureau of Health Professions and Board of Medicine filed a formal administrative complaint against Hodari and Nathanson in August 2007, charging negligence and incompetence. Specifically, the Bureau of Health Professions cites the lack of oxygen and resuscitation equipment available in the patient recovery room, the lack of standard monitoring equipment, and the fact that only one nurse was on duty in the recovery room with a total of 6-7 patients under her care. The lack of oxygen and resuscitation equipment and the fact that the nurse was alone in the patient recovery room (with no emergency call system to alert other staff) were significant factors in Regina Johnson's death. In fact, recovery room conditions at WomanCare were deemed "woefully inadequate and substandard."[43] In March 2009, the disciplinary case was closed with a finding of negligence and an order that Hodari pay a fine of $10,000.

After citing the facility for over 40 deficiencies in October 2009, BHS sent WomanCare a Statement of Deficiencies with the requirement that WomanCare submit a Plan of Correction. Hodari sent a letter January 18, 2010, stating that he would fix some of the violations but that others "cannot be fixed." Hodari and the Department engaged in phone conversations, and an email exchange that is not provided in the file.

On February 9, 2010, Hodari sent a letter requesting seven waivers of FSOF requirements. BHS considered those waiver requests, in violation of LARA administrative rule 325.3868a(2), which permits facilities to request waivers only at the time of application for a license. Broader problems with BHS's waiver policy will be discussed in the following section.

BHS refused at least one waiver request, an exemption from BHS's stipulation that WomanCare be equipped with an emergency exit. Rather than construct the emergency exit, Hodari sent BHS a letter on July 26, 2010 that he was surrendering his FSOF license. WomanCare continued to operate, and the Attorney General brought a suit against WomanCare on March 28, 2011, charging that the facility was operating illegally without FSOF licensure.

Though this case eventually resulted in an Attorney General lawsuit against the facility, this facility clearly never should have received licensure in the first place.

BHS's actions regarding WomanCare of Southfield raise significant concerns:

- BHS licensed a health facility where a patient death had occurred due to facility, equipment, and procedural deficiencies, then a year after granting licensure, found these same deficiencies still present at the facility.
- BHS did not conduct a desk audit, onsite inspection, or any verification of compliance with FSOF requirements prior to granting the license.

[43] Expert review conducted by Michael Hertz, M.D., who at the time was medical director of Planned Parenthood of South Central Michigan. In the Matter of Milton Nathanson, M.D., File No. 43-06-101294. Amended Opinion.

- BHS "fast-tracked" the application, actually mailing the clinic owner an invoice for the licensure fee before the owner even submitted the license application.
- BHS appeared unaware of the disciplinary action being taken against the facility owner for the patient death at Womancare when they granted the license.
- The fact that WomanCare had been in operation without FSOF licensure since 1975 and was only seeking licensure in 2008 following an MDCH audit failed to raise a red flag.
- BHS permitted WomanCare to seek waivers of FSOF requirements after they found and cited the facility for deficiencies.
- Nowhere does the BHS file indicate that BHS intended to visit WomanCare after granting the license; in fact, the deficiencies would not have been found if a complaint against the facility had not been made.

Section 5: Improper Waiver Procedures Allow Special Exemptions for Abortion Clinics

The Bureau of Health Systems allows all abortion clinics to request waivers that are broader in scope than those available to other health facilities, resulting in questionable exemptions available only to abortion clinics.

The 50% rule contains a grandfather clause allowing abortion clinics in operation before enactment of the statute to waive certain construction and/or equipment standards. However, BHS's waiver policy extends far beyond this narrow grandfather clause in two respects: (1) BHS is allowing abortion clinics in operation before enactment of the 50% rule to request far too many waivers, and (2) BHS is permitting *any* clinic to request construction and equipment waivers, not just those in operation prior to the 50% rule.

The Division of Licensing and Certification's form BHS-LC-103a, "Addendum for Pregnancy Termination Facilities Requesting Waivers," lists the requirements that may be waived for abortion clinics in operation before enactment of the 50% rule:

- Operating room lights and resuscitation equipment as appropriate for the type of surgery (R 325.3842)
- Medical records storage and work space for completing medical records (R 325.3848)
- Submission of floor plans and specifications (R 325.3855)
- Handicap accessible entrance and sufficient exterior lighting (R 325.3856)
- Interior construction, including emergency electrical service such as a generator (R 325.3857)
- Elevators (R 325.3858)
- Public and personnel areas, including bathroom requirements (R 325.3859)
- Communications--telephone and nurse call systems (R 325.3860)
- Clinical facilities, including minimum floor space for exam rooms and operating rooms, oxygen available for patients, scrub sinks, and sterilization equipment (R 325.3866)
- Areas for medication storage and preparation, other storage areas for linens, equipment, and soiled items (R 325.3867)

- Patient recovery areas with minimum floor space sufficient for a planned minimum 3-hour recovery period for all patients, and minimum number of beds or cots (R 325.3868)
- Heating and electrical systems with a temperature between 70° and 78° (R 325.3871)
- A central storage room and safe storage of hazardous or toxic materials (R 325.3877)

Many of the above requirements are minimum standards that should never be waived. For example, R 325.3842 requires resuscitation equipment appropriate for the type of surgery, 325.3860 mandate a nurse call system, and 325.3866 requires the availability of oxygen. All three requirements are imperative, as illustrated by the 2003 death of patient Regina Johnson at WomanCare of Southfield.

Another example of a minimum requirement that should not be waived is R 325.3848, mandating adequate space for storage of medical records "so located as to assure their confidentiality and protect them from access by unauthorized persons." Additional work space must also be provided for completing and maintaining medical records. Certainly, adequate storage of medical records that protects patient confidentiality and a workspace for creating and reviewing medical records is a minimum requirement for any health facility.

MCL 333.20115 does permit the Bureau of Health Systems to modify or waive any rules from R 325.3801-3877 "regarding construction or equipment standards, or both" for abortion clinics in operation before December 21, 1999. However, by their inclusion of this grandfather clause, it is doubtful that the legislature intended for abortion clinics in operation prior to the 50% rule be allowed to waive basic equipment such as resuscitation devices and nurse call systems, among other questionable items on the exemptions list.

The second main problem with BHS's practice relating to waivers is that abortion clinics not in operation before enactment of the 50% rule may also apply for waivers, per BHS's Addendum. That is, waivers are available for all currently operating abortion clinics that opened after 1999, and all that will open in the future.

BHS's "Addendum for Pregnancy Termination Facilities Requesting Waivers," lists these waivers for all post-1999 abortion clinics:

- Clinical facilities, including minimum floor space for exam rooms and operating rooms, oxygen available for patients, scrub sinks, and sterilization equipment (R 325.3866)
- Areas for medication storage and preparation, other storage areas for linens, equipment, and soiled items (R 325.3867)
- Patient recovery areas with minimum floor space sufficient for a planned minimum 3-hour recovery period for all patients, and minimum number of beds or cots (R 325.3868)

Again, many of these equipment and construction requirements never should be waived, including requirements for oxygen, scrub sinks, and patient recovery rooms.

There is no specific statutory authority allowing all abortion clinics to apply for waivers. MCL 333.20115 does not contain any provisions for waivers beyond the grandfather clause applying only to clinics in operation prior to enactment. LARA Administrative Rule is consistent with

MCL 333.20115. It does not provide for all abortion clinics to request waivers (See R 325.3868a).

It is unclear how the 50% rule grandfather clause evolved into a BHS policy of permitting all abortion clinics to request waivers of FSOF construction and equipment requirements.

In conversations with the Bureau of Health Professions, Larry Horvath, Director of Licensing, pointed to MCL 333.20145(8) as "blanket" authority for the department to allow any health facility to request waivers of licensure requirements: "The department may waive the applicability of this section to a construction project or alteration if the waiver will not affect the public health, safety, and welfare."

However, this statute permits the waiver of construction projects and alterations *only*, not required equipment. BHS did provide an example of LARA Administrative Rules permitting waivers of certain equipment requirements for psychiatric facilities. However, these waivers are only temporary and must be renewed yearly (R 330.1299), unlike waivers granted to abortion clinics, which may be in effect without renewal for as long as the clinic is in operation.

Finally, as explained in the previous section, BHS permitted Womancare to request waivers of FSOF requirements *after* Womancare had been cited for violations in those areas. This practice violated LARA administrative rule 325.3868a(2), which permits facilities to request waivers only at the time of application for a license.

BHS has not provided evidence that their waiver policy and practice for abortion clinics is consistent with that of all other facilities. BHS's practice regarding waivers effectively provides *special exemptions to all abortion clinics, exemptions not granted to any other type of health facility in the state*.

Section 6: Failure to Conduct State-mandated Annual Visits

MCL 333.20155 mandates annual visits to all FSOFs for "survey, evaluation, and consultation," yet the Bureau of Health Systems is in woeful violation of this statute. *BHS often fails to visit clinics even once every ten years*, and in one case, BHS never visited one abortion clinic that was in operation for at least 15 years. Abortion clinics engaging in the dangerous practices enumerated in Part I can continue such practices virtually unchecked for a decade or more. When BHS does conduct one of their infrequent visits, it always reveals serious breaches of FSOF requirements.

BHS has a long history of noncompliance with the annual visits mandate. A 2003 performance audit by the Office of the Auditor General found that BHS was not conducting statutorily mandated annual visits to FSOFs, hospices, and substance abuse treatment centers.[44] For 77% of all FSOFs, the last BHS visit had been 4 or more years prior to the audit. *Forty-two percent of FSOFs either had their last visit over 10 years prior, or had no visit on record.*

[44] Office of the Auditor General. "Performance Audit Bureau of Health Systems." January 2005. Available at <http://audgen.michigan.gov/comprpt/docs/r6345003.pdf>. Pgs. 13-15.

An MDCH follow-up in late 2005 revealed that BHS still was not conducting the visits, even though BHS had acknowledged their lack of compliance.[45] During the performance audit, BHS told the OAG that they sent "self-evaluation inspection forms" to FSOFs in lieu of the mandated visits. When MDCH conducted the follow-up, BHS said that the self-evaluation forms were a "one-time process," and they gave the OAG procedures that they had developed to prioritize and schedule visits to FSOFs. However, BHS said they did not have enough staff to conduct visits.

BHS files on licensed or formerly licensed abortion clinics illustrate the noncompliance cited in the OAG audit. For example, Planned Parenthood in Warren, which was in operation from 1991 to 2009, had held a license at least since 1996 but *did not have a single facility visit on file*.

Hodari's Flint abortion clinic, which has been licensed since the late 1970s, has only two visits on file, a November 2007 "relicensure survey" and a February 2010 visit pursuant to a complaint. The 2007 relicensure survey revealed four areas of noncompliance with FSOF regulations, including that the clinic failed to ensure sanitization of equipment, and failed to give a patient who was Rh Negative the RhoGam injection that the patient chart indicated the patient needed.

Goldfine's Birth Control Center in Sterling Heights obtained licensure in 1997 or earlier, but the file indicates only one visit, again a relicensure survey conducted in November 2007. The relicensure survey cited 10 areas of noncompliance with FSOF requirements, including failure to ensure sanitation of equipment, failure to have oxygen available for patients who may need it, and use of electrical heaters and extension cords that were a fire hazard.

On August 19, 2011, RLM had a phone conversation with Larry Horvath, the new Director of the Licensing and Certification Division for BHS. Mr. Horvath acknowledged that BHS has not conducted regular visits for many years, and that increasing the frequency and quality of visits is now a major focus for BHS.

Currently, since BHS visits to these clinics are so infrequent, abortion clinics can operate for a decade or more with serious deficiencies that endanger patient health.

Section 7: Abortion Clinic "Relinquishment" of Required License

Finally, BHS fails to take action consistently when clinics "relinquish" their mandatory license and stop paying license fees, but continue operating. On July 26, 2010, Alberto Hodari voluntarily "relinquished" his FSOF licensure for WomanCare of Southfield because he did not want to correct BHS-cited violations of FSOF requirements. BHS did refer that case to the Attorney General, and A.G. Schuette filed a lawsuit against WomanCare on March 28, 2011, for unlawful operation of a freestanding surgical facility without state licensure.

[45] MDCH Office of Audit. "Department of Community Health Bureau of Health Systems Follow-up Review." February 23, 2006.

However, in other cases BHS failed to take meaningful action. In 2007, Richard Goldfine's Birth Control Center was cited for 10 deficiencies, or areas of noncompliance with FSOF requirements, as discussed in the previous section. Rather than correct the deficiencies, Goldfine sent the department a letter stating that Birth Control Center was not an FSOF and "we do not want to be licensed by the State of Michigan as a freestanding clinic." BHS sent Goldfine two letters stating that they must either correct the deficiencies or demonstrate that the clinic no longer meets the 50% rule for FSOF licensure.

Goldfine simply stopped paying the annual license fee. He returned his 2008 invoice with the notation, "We are not a freestanding surgical facility. We are a private doctor's office." He has been operating the clinic without FSOF licensure since his license was terminated July 31, 2008. BHS has taken no further action. The abortion clinic is still in operation.

Other examples exist in BHS files of BHS failing to evaluate licensed clinics' claims that they no longer required FSOF licensure. For example, after having been licensed at least since 1996, Planned Parenthood of Warren sent BHS a fax on August 18, 2004, stating, "We no longer provide surgical terminations. No need for a license at this time." BHS follow-up consisted of a letter two weeks later informing Planned Parenthood that since the license had been relinquished, it was no longer valid and needed to be returned to the state. BHS did not request patient files demonstrating that surgical procedures were no longer performed.

BHS must develop and follow standard protocol for handling relinquishment of license that includes verification of the assertion that licensure is no longer needed. If the facility does in fact require continued licensure, then BHS must be consistent in taking enforcement action to ensure that clinics do not continue operating unlawfully.

Licensing Division Director Larry Horvath appears willing to take those steps. He stated that "the onus is on the department" to determine that the facility no longer requires licensure if they attest that they don't. He would propose obtaining patient statistics for the last 12 months to verify that abortion patients no longer comprise 50% of their practice. BHS would work in cooperation with the Attorney General to ensure that clinics are not continuing to operate without a license.

Part II Recommendations

BHS failure to ensure that abortion clinics hold mandatory licensure, and maintain minimum state health and safety standards, has enabled dangerously deficient clinics to continue operating unchecked for decades.

BHS should take the following actions to fulfill their duty to protect the public health and safety:

1. BHS must develop and implement a procedure for enforcing the 1999 "50% Rule" statute. Almost 90% of abortion clinics are operating without mandatory state licensure. Historically, abortion clinics have resisted licensure and only a small minority have ever been licensed. BHS may determine that the Attorney General should handle all

investigative work, and BHS's role is only department referral. If that is the case, BHS must refer consistently, document referrals, and follow up on referrals to ensure that the Attorney General's office takes timely action.

2. BHS must follow their own licensing protocol to ensure that facilities being granted licensure actually meet requirements. All pre-licensure activities must be documented in BHS files.

3. BHS must revisit their waiver policy so that unwarranted exemptions from FSOF requirements are not being granted to abortion clinics.

4. BHS must conduct state-mandated annual visits of freestanding surgical outpatient facilities. These visits should be unannounced. BHS should follow in a timely manner all procedures for handling instances of noncompliance discovered in annual visits.

5. BHS must develop and follow standard protocol for handling relinquishment of license that includes verification of the assertion that licensure is no longer needed. BHS must be consistent in taking enforcement action to ensure that clinics do not continue operating unlawfully.

Part III: Bureau of Health Professions and Licensing Boards Fail to Bar Unsafe Health Professionals

The Bureau of Health Professions and medical licensing boards fail to keep unsafe physicians from practicing in Michigan. About 20 doctors perform abortions in Michigan. Many have been disciplined by their medical licensing board, with complaint investigation and legal proceedings handled by the Bureau of Health Professions. However, many more allegations of abuse against physicians are not investigated. Even among allegations that are investigated, the state fails to take timely, appropriate disciplinary action with appropriate fines.

Sections 1-4 of Part III provide background information on the Bureau of Health Professions, and the licensing boards with which they work to license and discipline health professionals:

- Structure and duties of the Bureau of Health Professions,
- Structure and duties of the professional licensing boards,
- Statutory violations warranting state action and corresponding sanctions,
- Overview of the allegation investigation and sanction process.

Sections 5-9 detail disturbing failures on the part of the Bureau of Health Professions and medical licensing boards throughout this investigation and sanction process:

- Unacceptable delays during investigation and litigation, with BHP missing statutorily mandated timelines,
- Policy of not providing allegation reviewers with past and pending disciplinary actions against the medical professional in question,
- Binding allegation review decisions made by individual physicians with no oversight,
- Evidence that board members take advantage of the lack of oversight and fail to recuse themselves from allegation reviews of medical professionals with whom they have a prior relationship,
- Paltry fines that fail to recoup administrative expenses or deter bad medical practice.

Section 1: Bureau of Health Professions Structure and Duties

The mission of the Bureau of Health Professions within the Department of Licensing and Regulatory Affairs (LARA) is to protect public health by ensuring that healthcare providers meet required standards of practice. BHP licenses health professionals, ensures continuing compliance with licensure requirements, investigates complaints against licensed health professionals, and brings administrative lawsuits against health professionals whom they are charging with violations of the Public Health Code.

BHP consists of four divisions: Licensing, Allegation and Investigation, Regulatory, and Administration.

The Licensing Division licenses health care professionals in Michigan, and ensures that all licensees meet continuing education requirements. The Allegation and Investigation Division investigates allegations against licensed health professionals. The Regulatory Division files formal complaints against health professionals if the Investigation Division substantiates the allegation. The Regulatory Division also ensures that disciplined health professionals comply with sanctions issued by their licensing board, i.e., the Board of Medicine. They also oversee the promulgation of administrative rules. The Administration Division is responsible for policy direction and related support.

Section 2: Licensing Boards' Structure and Duties

The Michigan Public Health Code establishes the structure and responsibilities of Michigan's licensing boards for health professionals (MCL 333.16121-16169). There are 19 licensing boards. Those pertinent to this report are the Board of Medicine, which oversees roughly 36,000 M.D.s in Michigan, and the Board of Osteopathic Medicine and Surgery, which oversees almost 8,000 D.O.s.

All board members are appointed by the governor to 4 year terms. They may only serve 2 full terms. Serving an additional partial term is permissible if circumstances warrant. All boards must elect a chairperson and other officers to serve one-year terms. (MCL 333.16139).

These boards work closely with the Bureau of Health Professions to regulate health professionals, and have considerable authority regarding disciplinary action against health professionals. This authority will be discussed further in Section 4, which details the patient allegation investigation and disciplinary process.

Section 3: Violations of the Public Health Code and Sanctions

MCL 333.16221 enumerates the violations that warrant sanction of a licensed medical professional, and Sec. 16226 lists corresponding sanctions. Table 2 lists violations and corresponding sanctions. Not all violations are included in this list.

Abortion doctors who are disciplined are most commonly charged with the following violations: (a), negligence, failure to exercise due care; (b)(i), incompetence; (b)(vi), lack of good moral character. Though these violations carry a maximum fine of $250,000, most are $10,000 or less. The problem of low fine amounts that fail to deter bad behavior and fail to recoup department investigation and litigation costs will be addressed in Section 9.

Table 2: Public Health Code Violations & Sanctions

Subsection	Violation	Sanction
(a)	Violation of general duty, negligence, failure to exercise due care	Revocation of license, suspension, limitation on license, probation, restitution, community service, fine of up to $250,000
(b)(i)	Incompetence	
(b)(ii)	Substance abuse	
(b)(iii)	Mental or physical impairment affecting ability to practice	
(b)(iv)	Mental incompetence as declared by court	
(b)(v)	Felony or misdemeanor with max sentence of 2 years; or misdemeanor of illegal delivery, possession or use of drugs	
(b)(vi)	Lack of good moral character	
(b)(vii)	Criminal conviction of sexual conduct offense	
(b)(ix)	Fraud in obtaining fees for services	
(b)(x)	Action against licensee in other state or by federal government	
(b)(xi)	Misdemeanor conviction affecting competence	
(b)(xii)	Practicing under the influence	
(b)(viii)	Falsification/altering of medical records	Revocation of license
(c)(i)	Fraud in obtaining or renewing license	Revocation of license, suspension, limitation on license, probation, restitution, community service, fine of unspecified amount
(c)(ii)	Allowing unauthorized person to use license	
(c)(iii)	Practice outside scope of license	
(c)(iv)	Obtaining or attempting to obtain drugs unlawfully, selling drugs, prescribing drugs without medical reason	
(d)(i)	False or misleading advertising	Probation, restitution, community service, fine, reprimand
(d)(ii)	Kickbacks on services, or dividing fees	
(e)(i)	Misrepresentation to patient to get 3rd party reimbursement	Suspension, limitation on license, probation, restitution, community service, fine, reprimand
(e)(ii)	Betrayal of professional confidence	
(e)(iii)	Promoting drug or treatment for personal gain	Revocation of license, suspension, limitation on license, probation, restitution, community service, fine
(h)	A violation of this article of the Public Health Code or aiding and abetting in a violation. Would include mishandling medical records (Sec. 16213)	
(l)	Failure to meet requirements for licensure	Reprimand, denial or limitation of license
(m)	Violation of Informed Consent Law for abortion	Revocation of license, suspension, limitation on license, probation, restitution, fine, reprimand
(n)	Violation of Partial-Birth Abortion Ban	Revocation of license
(q)	Violation of Human Cloning Ban	
(s)	Violation of Medical Records Access Act	Revocation of license, suspension, limitation on license, probation, restitution, community service, fine
(t)	Adulterate or misbrand drugs; sell adulterated or misbranded drugs or substitute a drug	Revocation of license, fine and restitution

Section 4: Allegation Investigation and Disciplinary Process

State statutes and LARA administrative rules establish a detailed process for receiving allegations, investigating potential violations of the Public Health Code, and sanctioning physicians through administrative court proceedings. This process is explained below.

The public may make allegations against licensed health professionals to BHP either by mail, phone, or through the Internet. BHP receives the allegations and date-stamps them, then forwards them to the Allegations Section.

The Allegations Section enters allegations into a tracking database, which assigns a file number. However, not all allegations are entered. The Allegations Section screens out some applications if the Section determines that BHP does not have jurisdiction in the matter. Unacceptable delays for entering allegations into the system are discussed in Section 5.

After the Allegations Section enters the allegation into the database, generating an allegation file number, the Allegations Section reviews the allegation. They determine whether they need medical records, police reports, court proceedings, or other documentation, then obtain that documentation. Unacceptable delays at this step are also discussed in Section 5.

The Allegations Section then sets a time with members of the various licensing boards to come to BHS offices and process allegations.

The boards decide whether to authorize the allegation for investigation, return the file to BHP for BHP to obtain more records, or close the allegation with no investigation. State statute and LARA administrative rules mandate that the applicable licensing board must authorize an investigation before any investigation may commence (MCL 333.16231(2), R. 338.1603). BHP is precluded by Section 16231(2) of the Public Health Code from conducting an investigation without authorization by a licensing board. The only exception is that automatic investigation is mandated if the board member(s) have taken more than 7 days to make their decision.

Board of Medicine meeting minutes for 2009 and 2010 indicate that in both years, 55% of patient allegations were authorized for investigation. In 2009, 43% were closed without investigation, and in 2010, 36% were closed. The remaining patient allegations were returned to BHP for BHP to obtain additional records, such as medical records.

Serious deficiencies in this critical step of authorizing or not authorizing an allegation for investigation are covered in Sections 6-8.

If the board does authorize investigation, a trained investigator within the Allegation and Investigation Division investigates. This investigation includes interviews with the complainant, the licensed health professional, and any witnesses. The investigator also gathers other evidence.

If the allegation is substantiated through investigation, the Allegation and Investigation Division sends the file is sent to the Regulatory Division, which files a formal administrative complaint against the health professional. The Attorney General's office actually prepares the complaint,

acting as BHP's legal representative. Under MCL 333.16231(5), the Bureau of Health Professions has 90 days from the start of the investigation either to file a formal administrative complaint, or dismiss the complaint. A 30 day extension is permitted.

The licensee has 30 days to respond or is subject to automatic sanction. If there is an imminent threat to the public's health, safety or welfare, the Bureau of Health Professions can summarily suspend a license or registration, with the "okay" from the chair of the appropriate licensing board. According to Sec. 16233, the Bureau of Health Professions must issue a summary suspension if the licensee has been convicted of a felony, a misdemeanor punishable by up to 2 years, or a misdemeanor involving illegal possession, use or delivery of a controlled substance. This summary suspension prohibits the medical professional from practicing during the administrative process.

BHP then holds a compliance conference in order to negotiate a settlement. A member of the appropriate board may participate in the conference and facilitate an agreement. The proposed settlement may include a fine, a probation period, a reprimand, a restriction on the professional's practice, a suspension, or a revocation of license to practice in Michigan. License revocation is usually for three years. MCL 333.16226 details the appropriate sanctions for various violations. Alternatively, the complaint may be dismissed.

The appropriate board must approve the settlement. Specifically, the board's disciplinary Subcommittee approves the settlement.

If the Disciplinary Subcommittee rejects the settlement, or no settlement is reached at the conference, an administrative hearing is held before an administrative law judge within 60 days (Section 16231a). The judge issues a determination regarding whether the health professional violated the Public Health Code, and if so, sanctions that should be imposed.

The judge's determination goes back to the disciplinary subcommittee of the appropriate board. The disciplinary subcommittee votes either to accept the judge's determination, or reject it and write their own determination regarding whether or not a violation of the Public Health Code was proven. It appears from a review of Board of Medicine Disciplinary Subcommittee meeting notes that the disciplinary subcommittee almost always approves the judge's determination.

If the health professional did violate the Public Health Code, a Consent Order is issued in the administrative court with the final, binding determination regarding which statutes were violated. Under MCL 333.16237, this final action must be taken within one year from the start of the investigation, if the lawsuit does not settle.

The sanctioned health professional may appeal the final Consent Order.

It is important to note that while the Bureau of Health Professions is responsible for protecting the public health by ensuring that health professionals maintain required standards of practice, *the various licensing boards have significant authority in the allegations and complaint process*:

- The board authorizes allegations for investigation
- The board must approve the summary suspension of a license while an administrative lawsuit is pending against the health professional

- The board disciplinary subcommittee approves settlements of administrative lawsuits
- The board disciplinary subcommittee makes the final decision regarding whether and how a licensed health professional will be sanctioned

In practice, this process is seriously compromised by multiple failures on the part of licensing boards and the Bureau of Health Professions.

Section 5: Unacceptable Delays in the Investigation and Litigation Process

The Bureau of Health Professions fails to investigate and litigate patient cases against health professionals in a timely manner, even missing statutorily-mandated deadlines. The public health and safety is compromised due to this failure to investigate and resolve allegations from patients and other state agencies.

The Bureau of Health Professions has a history of unacceptable delays in resolving allegations. A 2003 Auditor General audit of the Bureau of Health Services, (renamed the Bureau of Health Professions in December 2003[46]) uncovered particularly egregious delays at two points in the process: initial review, and resolution of disciplinary action.[47] The audit found that the Bureau failed to conduct their initial review "in a reasonable time period" for 42% of randomly selected allegations. One audited file showed *a delay of 118 days—four months— simply to enter the received allegation into the computer tracking system and generate a file number*, the first step in reviewing the allegation. The average was over 17 days for this first step. Moreover, state law mandates that final disciplinary action must be taken within one year after the initiation of an investigation (MCL 333.16237). The audit found that 5% of randomly selected cases were not resolved within one year.

These delays continue today. In one case filed in June of 2009, *BHP's initial allegation review took ten months*.[48] This was the allegation filed by the physician who treated the abortion patient of Robert Alexander, who performed an incomplete abortion on the patient in question when she was at 26 weeks gestation. Recall that this initial review involves entering the file into the computer system, and gathering documentation such as medical records in order to forward the file to the appropriate board. It is not an investigation. In fact, this case was not authorized for investigation, which will be addressed in more detail in Section 8.

Files show long delays during the investigation process as well. In the 2008 illegal dumping incident involving Alberto Hodari and others, a citizen filed an allegation against Alberto Hodari

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[46] The Bureau of Health Services became the Bureau of Health Professions in December 2003, and operations were transferred from the Department of Consumer & Industry Services to the Department of Community Health. BHP is now housed within the Department of Licensing and Regulatory Affairs (LARA), created in 2011.

[47] Office of the Auditor General. "Performance Audit Bureau of Health Services." April 2004. Available at <http://audgen.michigan.gov/comprpt/docs/r6343003.pdf>. Pgs. 17-19.

[48] File No. 43-112676, Opened June 12, 2009 against Robert Lewis Alexander, M.D. Closed without investigation April 29, 2010.

with the Bureau of Health Professions on March 11, 2008.[49] An investigation commenced that same month, and the file was not closed until January 6, 2010, twenty-two months after BHP received the allegation and opened investigation.

In another recent case, it took BHS 33 months—almost 3 years—from the opening of the allegation to the close of investigation and filing of the formal Administrative Complaint. It was another 12 months until the disciplinary lawsuit was resolved with sanctions issued against the medical professional, *for a total case time of 45 months*.[50]

In the 2004 disciplinary action against Michael Roth, the state received the allegation on November 16, 2000. The Administrative Complaint was not filed until October 16, 2003—35 months after the allegation was received. Sanctions were imposed May 19, 2004, for a total case time of 42 months.[51]

Moreover, BHP still fails to comply with the statutory mandate to resolve disciplinary lawsuits and issue sanctions within one year of filing the formal Administrative Complaint. In the 2003 death of abortion patient Regina Johnson, *BHP exceeded the statutorily mandated 12-month resolution period by 7 months*. BHP filed the Administrative Complaint against Alberto Hodari on August 6, 2007, and the final order imposing sanctions and resolving the matter was filed 19 months later on March 18, 2009.

BHS employees have given several reasons for delays. Regarding delays in the initial review process, BHP FOIA Coordinator Mary Hess said that obtaining records can be a lengthy process, and BHP often must subpoena medical records and other information.[52] In addition, Ms. Hess stated that the Bureau is extremely busy and they are "backed up," with many new medical areas to monitor in the last few years, including medical marijuana.

Regarding noncompliance with the 12-month mandate for legal proceedings, BHS told the Office of the Auditor General in 2003 that these delays are due in part to circumstances outside their control, such as uncooperative witnesses and criminal actions taking precedence over administrative actions.[53] In addition, it appears that the Board of Medicine does not fulfill their duties as efficiently as other boards. All cases cited above involved medical doctors, with the Board of Medicine working in conjunction with BHP to resolve legal proceedings. Cases involving D.O.'s are resolved much more quickly, indicating greater efficiency on the part of the Board for Osteopathic Surgery and Medicine. For example, BHP and the D.O. Board resolved in less than 3 months the 2005 case against Reginald Sharpe, in which the abortion patient gave birth to a stillborn baby after lying in the recovery room unattended for 3 hours. The Administrative Complaint was issued one week after BHP opened the file, and sanctions were imposed by final court order only 70 days later.

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49 File No. 43-08-107813.

50 In the Matter of Robert Craig Levine, M.D., File No. 43-06-102668. Sanctions imposed through a final Order May 26, 2010.

51 In the Matter of Michael Arthur Roth, M.D., Complaint No. 43-00-2832-00.

52 Conversation with Mary Hess, FOIA Coordinator, Bureau of Health Professions, August 3, 2011.

53 Pg. 19.

Whatever the reason for the delays, it is clear that they endanger public health. Investigation and litigation processes that exceed statutorily mandated timelines allow unsafe medical professionals to continue operating for years.

Often other patients are filing additional allegations against these physicians while investigations and disciplinary actions in other matters languish. During the 19 months that BHP was litigating the suit against Alberto Hodari in the death of Regina Johnson, a total of 4 additional allegations were filed against Hodari, two of which were dismissed without an investigation. In addition, during this period, his abortion clinic where the patient death occurred, Womancare of Southfield, received FSOF licensure.

In 2005, the Michigan Health and Safety Commission found that the state needed to improve their processes for timely license revocation and other disciplinary action against dangerous medical professionals. Their 2005 report recommends that state oversight agencies and licensing boards develop systems that would "more quickly and effectively identify and remove from practice unsafe professionals."[54]

Section 6: Barriers to Identifying Patterns of Unsafe Practice

The licensing board's decision to authorize an allegation for investigation or dismiss the allegation is a critical step in the disciplinary process. The licensing board alone has authority to authorize investigations. If the board authorizes investigation, the board sets in motion a chain of events that may lead to sanctions, and potentially the removal of an unsafe medical practitioner through revocation of license. If the board does not authorize investigation, the allegation file is closed, with no mechanism for the Bureau of Health Professions to challenge the board's decision.

However, the board members who review allegations are unable to identify dangerous patterns of bad medical practice, because BHP does not include essential background information about the health professional in the review file given to board reviewers. The files that BHP gives to the board members for review contain the patient allegation to be reviewed and any records pertaining to that particular allegation, such as medical records. BHP does not include in the review file any of the following: past violations of the Public Health Code, pending administrative lawsuits against the health professional, pending investigations, prior allegations unsubstantiated after investigation, or prior allegations not authorized for investigation.

Therefore when allegations come to board reviewers, the reviewer has no background information about past allegations, either substantiated or not, that would signal patterns of unsafe practice.[55]

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[54] Michigan Health and Safety Coalition acting as the Michigan State Commission on Patient Safety (2005). *Call to action: A plan to improve patient safety in Michigan's health care system.* Southfield, Michigan: Michigan Health and Safety Coalition. Pg. 48.

[55] BHP's philosophy runs directly counter to well-established medical error research, which emphasizes the need for mechanisms that can identify *patterns* of unsafe practice that jeopardize patient health.

BHP does maintain documentation on past violations, current pending actions, and other patient allegations. Substantiated allegations and disciplinary actions are retained indefinitely, and unsubstantiated allegations, including those not authorized for investigation, are retained for at least five years, as mandated by state law. (MCL 333.16211(5))

BHP does not include any of this documentation due to a bureau philosophy that "each allegation should be considered on its own merit," as explained to RLM by Ray Garza, Director of the Allegation and Investigation Division of BHP.[56]

This philosophy prevents board reviewers from recognizing patterns and taking action against medical professionals who endanger patients. For example, two women recently filed allegations that Alberto Hodari and/or staff forced them to undergo abortion procedures. The alleged facts are disturbingly similar, including that Hodari and/or a staff member used force to hold the struggling women onto the table, and Hodari ordered an assistant to cover the mouths of the women. The board reviewer received the second allegation in mid-February 2010. The file given by BHP would have contained information pertinent only to that allegation.
The following information would *not* have been included:

- The first forced abortion allegation, made in 2008, which the board reviewer did not authorize for investigation
- A December 2007 patient allegation of unknown nature that was investigated and unsubstantiated
- A March 2008 allegation by a concerned citizen regarding the illegal dumping incident
- An August 2008 file that was opened by BHP in response to the Oakland County charges of illegal disposal of patient medical records in the illegal dumping incident
- The March 2009 administrative court finding that Hodari was negligent in the 2003 death of abortion patient Regina Johnson, and final order issuing a $10,000 fine

Particularly at unlicensed abortion clinics, operating with no state oversight, *the only alarm system for unsafe physicians that repeatedly commit medical errors and breaches of professional duty are patient complaints*. In order for these patient complaints, or allegations, to be given the consideration they deserve, board reviewers need to have information on past disciplinary actions and allegations. BHP's policy that board reviewers should not have access to this information creates another barrier to identifying and sanctioning unsafe abortion doctors.

Section 7: No Collaboration, Oversight or Uniformity in Critical Decisions

In the critical step of authorizing or not authorizing allegations for investigation, another serious deficiency is the fact that this weighty decision usually is made by a single board member, with no meaningful oversight either by the licensing board or BHP. This individual board member makes these binding decisions without any established criteria, in effect using his or her own criteria for authorizing or not authorizing investigation.

[56] RLM conversation with Ray Garza on August 3, 2011.

Mary Hess explained that the boards send one or, at most, two members to BHP offices to review allegation files onsite.[57] The reviewer takes a stack of allegations, and works through them, individually filling out the "Board Review Sheet" for each allegation, stating whether or not the allegation is authorized for investigation. An example of a completed Board Review Sheet is included as Appendix A.

Historically, the boards have not reviewed these decisions. The Board of Medicine does have a six-member Investigations and Allegations Committee, composed of medical professionals and members of the public. However, it appears that only the physicians on the committee make these decisions, and they do so individually, using their own criteria.

Board of Medicine meeting minutes indicate attempts by the committee chair to make the allegation review a more collaborative and uniform process. The May 2010 committee report from the Investigations and Allegations committee states, "[Committee Chair Dr. Richard Burney] stated that at the end of each committee meeting he is asking each committee member to share what types of cases they have reviewed and have committee dialogue regarding the decision rendered. Burney indicated that he is seeking more committee involvement in each case that is being reviewed."[58] The July 2010 meeting minutes contains an update: "Burney stated that each time the Committee meets, discussion is held to review the decisions that were made in an attempt to achieve uniformity in the decision making process."

These meeting notes provide *evidence of the longstanding practice for this critical decision to be made by individual board members with little or no input from other members, including the non-physicians on the board.* In addition, the decision-making process lacks uniformity, with each individual physician using his or her own criteria. Whether or not the process truly has become more collaborative and standardized remains to be seen.

BHP also has no meaningful oversight of this allegation review by the individual board member. The manager of the Allegation Section reads the returned Board Review Sheet, and indicates on the sheet whether she concurs with the board member's decision, or disagrees. However, all Board Review Sheets obtained by RLM show BHP concurrence with the Board decision. As a practical matter, dissent would be meaningless. State statute mandates licensing board approval to initiate an investigation. BHP has no mechanism for challenging a board member's decision, as confirmed by Allegations & Investigations Division Director, Ray Garza.[59] The manager's "check off" is a meaningless rubber stamp.

Finally, and of particular concern, is the evidence that individual board members are taking advantage of this lack of collaboration, oversight and standardization. They are abusing their power and protecting health professionals with whom they have prior relationships, rather than recusing themselves from allegation reviews when appropriate, as detailed in the next section.

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[57] RLM conversation with Mary Hess, FOIA Coordinator for Bureau of Health Professions, August 3, 2011.

[58] Michigan Board of Medicine Meeting Minutes. May 26, 2010. Investigations and Allegations Committee Report.

[59] RLM conversation with Ray Garza, Director of the Allegation & Investigation Division, BHP, August 3, 2011.

Section 8: Board Member Failure to Recuse

The licensure history of abortion doctor Robert Alexander reveals questionable review decisions and a failure to recuse himself on the part of past Board of Medicine President, Dr. George Shade.

Robert Alexander received his Michigan M.D. license in December 1981, and immediately began working at Kai Medical Clinic on 7 Mile in Detroit, which advertised as a weight loss clinic. There he was paid to prescribe Valium, Percocet, Predulin and Desoxyn (Methamphetamine) to patients he never saw. Undercover law enforcement received prescriptions from him and several other doctors throughout 1982 and 1983. In 1988, a jury trial convicted Alexander of 11 counts of illegal distribution of controlled substances. Alexander served almost two years in a North Dakota prison and was on parole from 1990 to 1996.

In December 1988, the A.G. filed an Administrative Complaint against Alexander to revoke his license. Alexander voluntarily surrendered his license in 1989, while he was still serving his prison sentence. If he had not voluntarily surrendered his license, the Bureau of Health Professions would have issued a Summary Suspension of Alexander's license to prohibit him from practicing during the administrative process, in accordance with MCL 333.16233.

In 1990, an administrative hearing was held. The administrative law judge found that Alexander had committed numerous violations of the public health code. The Board of Medicine accepted the law judge's finding and revoked Alexander's license, also fining him $50,000. Alexander appealed three times, unsuccessfully.

Medical professionals with revoked licenses can reapply in three years. Alexander reapplied in 1993. In 1995, the Board denied reinstatement, after a psychiatric evaluation ordered by the Board. This evaluation confirmed Alexander's lifelong bipolar disorder. In their denial, the Board stated, "To this day, Petitioner refuses to answer questions concerning his misconduct. Petitioner has failed to submit proof that he has learned from this experience."[60]

Alexander then requested and was granted a reconsideration hearing. For the reconsideration hearing, Alexander submitted as his first exhibit a letter from Dr. George Shade, vouching for Alexander. Dr. Shade was a practicing OB/Gyn at Detroit Riverview Hospital and a clinical professor at Wayne State at the time.

At the reconsideration hearing, Alexander testified that Dr. Shade would take Alexander under his wing.[61] If the Board were to grant a limited license, Dr. Shade would act as the required

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[60] State of Michigan Department of Commerce, Bureau of Occupational and Professional Regulation, Board of Medicine, In the Matter of Robert L. Alexander, File No. 43-86-0330, Board's Findings of Fact and Conclusions of Law for Final Order Denying Reinstatement, September 29, 1995, Pg. 2.

[61] State of Michigan Department of Commerce, Bureau of Occupational and Professional Regulation, Board of Medicine, In the Matter of Robert L. Alexander, File No. 43-86-0330, Transcript of Proceedings on March 21, 1996, Pgs. 8, 11, 31-33.

supervisor for Alexander during a mandatory retraining period. Alexander would work under Dr. Shade at Detroit Riverview Hospital, and if granted a full license, Dr. Shade would help him become a full-fledged employee of the hospital.

The Board granted Alexander a limited license following this hearing. Dr. Shade served as Alexander's supervisor during the retraining period at Riverview Hospital. In 1997, Alexander petitioned for his license to be reclassified from "limited" to "full." The Board first denied the license because Alexander failed his medical exam for recertification. Alexander retook the recertification exam and passed. In 1998, the Board granted him a full M.D. license. In 1999, they reissued the $50,000 fine, which Alexander had never paid. That fine was then reduced to $25,000 in 2000.

It doesn't appear that Alexander ever became an employee of Detroit Riverview, but Dr. Shade assisted him professionally in other ways. Alexander became a member of the Wayne County Medical Society in 2009, the year that Dr. Shade was installed as President of the Society. Alexander was also a 2011 Wayne County delegate to the Michigan State Medical Society, even though his only known medical practice is his abortion clinic in Muskegon. Dr. Shade serves as a District Director for Wayne County with the Michigan State Medical Society.

Dr. Shade was appointed to the Board of Medicine by Governor Granholm in 2004. He served as a member of the disciplinary subcommittee for several years, became vice-chair in 2009, and chairman in 2010.

The Bureau of Health Professions received an allegation against Alexander in May 2006, and another in June 2009. Dr. Shade, a member of the Investigations and Allegations Committee at the time, reviewed both and did not authorize investigation for either allegation. [62]

The 2006 allegation contained 7 affidavits compiled by a prolife advocate alleging that Alexander was violating medical waste laws, Michigan's informed consent for abortion law, and the 50 percent rule by operating his Ypsilanti abortion clinic without FOSF licensure. Provided as evidence of the latter charge was the clinic document described in Part 1, Section 7, in which the clinic instructs patients that they do not have to read the state-mandated informed consent information. The affidavits also alleged that the clinic was dirty and unsanitary with sub-standard conditions, and Alexander was willing "to do abortions beyond point of viability," under circumstances that the affiant considered legally questionable. One affidavit alleges that Alexander appeared to be intoxicated while working at the abortion clinic.

The allegations included 6 photos of Alexander's previous abortion clinic in Ann Arbor, shortly after he had been evicted from the building. Photos depict used syringes on the floor, open containers that held blood and other medical waste, and blood splattered on the floor and walls.

Dr. Shade did not authorize an investigation, and he wrote as his explanation: "Abortion is legal in the state of Michigan. Whether or not any given individual/s agree with this is a personal matter between that person and his or her conscience. It does not change the law as it stands.

[62] Of all patient allegations received by the Bureau of Health Professions, the majority—55%—are authorized for investigation (Section 4).

There is no violation of the state health code. This file reflects an active campaign to discredit and prevent a physician from practicing because he chose to follow his own conscience and the law and perform medical abortions." Dr. Shade's Board Review Sheet with this statement is included as Appendix A.

Dr. Shade then reviewed and did not authorize investigation of a second allegation, made against Alexander in June 2009. It is this allegation which languished for ten months in BHP's initial review process, as explained in Section 5.

Alexander had since moved his abortion business to Muskegon. This allegation was filed June 12, 2009, by an unidentified OB/Gyn who was providing medical care for a woman who went to Alexander seeking abortion. The woman paid Alexander for the abortion, and Alexander did an ultrasound, then "stuck something up inside her and moved it around, removing something." She left the clinic. Four and a half weeks later, she went to the hospital emergency room for pain and movement in her abdomen, and ER staff found that she was still pregnant and 30 weeks along. She was transferred to labor and delivery and came under the care of the OB/Gyn who made the complaint. The OB/Gyn called Alexander, and Alexander said he did a "limited ultrasound," but the ultrasound was difficult due to the patient's obesity. He said he did remove a "gestational sac." The patient informed the OB/Gyn that Alexander later had called her many times offering to refund her money and give her an additional $200.00, which she refused.

The allegation states: "It is my opinion that Dr. Alexander was grossly negligent in this case. At the time of the elective termination the patient would have been approximately 26 weeks pregnant. No matter how obese the patient was, he should have visualized a viable intrauterine pregnancy. If he would have ruptured the membranes he could have killed the fetus or been responsible for delivering a premature neonate. If he had placed the suction curette through the placenta the patient would have bled to death."

The OB/Gyn then briefly describes another patient who had come under his care following an abortion performed by Alexander. Alexander had severely perforated her uterus during an abortion at 8 weeks. The woman was unable to walk for a month due to pain.

More than 10 months after BHP received the allegation, Dr. Shade did not authorize an investigation in his April 21, 2010, completion of the Board Review Sheet. His reason for not authorizing investigation is as follows: "Appropriate evaluation of the patient was performed. She was outside the legal limit for voluntary termination of pregnancy and was informed of such by the licensee. Patient was refunded payment. No breach of standard care, no fraud, no unethical practice."

Presumably the information that Dr. Shade cited came from the abortion clinic medical records that BHP likely obtained and included in the file. Dr. Shade fails to explain why this information differs considerably from the facts alleged by the treating OB/Gyn, including the OB/Gyn's own telephone conversation with Alexander. According to the allegation, Alexander's evaluation of the patient was negligent, Alexander accepted payment for the abortion, and the woman left the clinic believing she had obtained an abortion.

In addition, Dr. Shade does not explain the discrepancy regarding repayment of the abortion fee, and he fails to mention at all the extra $200 that the allegation claims Alexander repeatedly offered to the woman. Finally, Dr. Shade's explanation also fails to address the fact that this woman was the second abortion patient of Alexander's to come under the care of the OB/Gyn after suffering severe complications.

The review process for both these allegations raises several concerns:

1) Dr. Shade clearly had a longstanding professional relationship with Robert Alexander and should have recused himself from a review of both allegations. Dr. Shade was instrumental in helping Alexander get his license reinstated after Alexander's felony drug conviction. Dr. Shade also appears to have paved the way for Alexander's later involvement in medical professional societies.
2) Dr. Shade dismisses the 2006 allegation apparently because a prolife advocate compiled it. He ignores the affidavits, the photographs of biohazard waste, and the WomansChoice document obtained outside the clinic, informing patients that they do not have to read the state-mandated informed consent materials.
3) In the 2009 allegation, more than 10 months lapsed from the time that BHP received the allegation to the decision by Dr. Shade not to authorize investigation.
4) Dr. Shade's brief written explanation dismissing the 2009 allegation provides no explanation of the considerable disparity between the facts alleged by the treating OB/Gyn and information presumably gleaned from the abortion clinic medical records. Dr. Shade also failed to address significant elements of the allegation.

In a conversation with Ray Garza, Director of BHP's Allegation & Investigation Division, RLM asked Mr. Garza if the licensing boards have a policy regarding recusal. He said that each board handles the issue on their own, and he does not believe failure to recuse is a problem. BHP trains new board members, which involves telling them that they need to recuse themselves if they have some sort of relationship with the medical professional in question.

However, recusal when appropriate is not happening consistently, resulting in questionable decisions at a critical point in the allegation process. *These decisions are binding, with no avenue for BHP or any other entity to appeal.*

Section 9: Trivial Administrative Fines Fail to Recoup State Costs

Finally, even when a patient allegation is authorized for investigation and that investigation leads to sanctions, paltry fines fail to recoup state expenditures for investigation and litigation, and fail to deter future violations.

Both state statute and LARA administrative rules give licensing boards wide latitude to levy fines that will deter bad practice and enable the state to recoup costs. A licensing board may impose a fine of up to $250,000 for any one of 12 separate violations, including negligence, incompetence, and "lack of good moral character." (MCL 333.16226). Maximum fine amounts for other violations are not specified in law. LARA administrative rule 338.2308 states that when assessing a fine, the licensing board shall take into consideration "the cost incurred in investigating and proceeding against the licensee," as well as "the public harm, actual or potential, caused by the violation."

Fines issued by the Board of Medicine fail to reflect the serious nature of the violations, and would not cover even a fraction of investigation and litigation costs. The Board of Medicine fined Robert Levine, M.D., *only $2,500 for negligence in a patient death—after 45 months of investigation and litigation.*[63] This case was cited in Section 5 regarding unacceptable delays in the disciplinary process. Lewis Twigg, M.D., who was found negligent for allowing unlicensed staff to administer Valium was fined only $1,000. Alberto Hodari received a $10,000 fine following 11 months of BHP investigation and 19 months of litigation in the 2003 death of abortion patient Regina Johnson. The doctor who performed that abortion, Milton Nathanson, M.D., was fined only $1,000.

The largest fine in files obtained by RLM is $50,000, levied against Robert Alexander, M.D., in 1990 by the Board of Medicine, along with revocation of Alexander's license following his felony drug conviction. Alexander appealed the revocation of license and $50,000 fine three times. Alexander never paid the fine, and 10 years later, in 2000, the Board reduced the fine to $25,000.

The Board of Osteopathic Medicine also issues fines that would not cover state expenses. The Board fined Reginald Sharpe, D.O., $2,500 for allowing unlicensed staff to administer Valium at the abortion clinic where he worked with Lewis Twigg. The Board fined Sharpe $5,000 for leaving an abortion patient completely unattended for three hours, during which time she gave birth to a stillborn baby in the recovery room.

Table 3 summarizes fines issued by the Board of Medicine and Board of Osteopathic Medicine and Surgery in disciplinary actions.

[63] In the Matter of Robert Craig Levine, File No. 43-06-102668. Sanctions imposed through a final Order May 26, 2010.

Table 3: Medical Board Disciplinary Actions

Medical Professional	Licensing Board	Violation of Public Health Code	Incident	Case Timeframe	Fine
Robert Alexander	Board of Medicine	16221(a), negligence; (b)(i), incompetence; (b)(v), felony conviction; (b)(vi), lack of good moral character; (c)(iii), practice outside scope of license; (c)(iv), selling or prescribing drugs without medical reason	Felony drug conviction, selling drug prescriptions	51 months, excluding appeals	$50,000, reduced to $25,000
Robert Levine	Board of Medicine	16221(a), negligence	Patient death	45 months	$2,500
Michael Roth	Board of Medicine	16221(a), negligence; (b)(i), incompetence; (b)(vi), lack of good moral character	Performing abortions in patient homes, controlled substances violations, informed consent law and other violations	42 months	$15,000
Alberto Hodari	Board of Medicine	16221(a), negligence	Patient death	30 months	$10,000
Lewis Twigg	Board of Medicine	16221(a), negligence; (h), violation of article or aiding & abetting in violation (16215(1))	Permitting unlicensed staff to administer controlled substances	23 months	$1,000
Milton Nathanson	Board of Medicine	16221(a), negligence	Patient death	22 months	$1,000
Ronald Nichols	Board of Medicine	16221(a), negligence; (b)(i), incompetence; (b)(vi), lack of good moral character	Gross medical error in 20 week abortion, denies patient emergency care	20 months	$10,000
Reginald Sharpe	Board for Osteopathic Medicine	16221(a), negligence; (h), violation of article or aiding & abetting in violation (16215(1))	Permitting unlicensed staff to administer controlled substances	9 months	$2,500
Reginald Sharpe	Board for Osteopathic Medicine	16221(a), negligence; (b)(i), incompetence; (b)(vi), lack of good moral character	Unattended patient delivers stillborn baby, denies patient emergency care	2.5 months	$5,000

Part III Recommendations

The Bureau of Health Professions and the state medical licensing boards issue paltry fines that do not recoup state costs or deter bad practice, have a history of unacceptable delays when investigating and litigating cases against health professionals, and fail to ensure a fair, standardized procedure for allegation review. All of these deficiencies enable unsafe medical practitioners to continue operating in Michigan.

BHP and the licensing boards should take the following actions to fulfill their duty to protect the public health and safety:

1. Licensing boards must develop guidelines for issuing fines that will recoup state costs and take into consideration the public harm caused by the violations, in accordance with LARA administrative rules.

2. Licensing boards must revisit recusal policies and ensure that medical professionals are recusing themselves from cases where appropriate.

3. Licensing boards must create and implement allegation review procedures that are uniform and involve the public members on the board as well as medical professionals.

4. BHP must create allegation review procedures that provide for meaningful department oversight of licensing board decisions.

5. BHP must remove barriers to the identification of patterns of bad practice. BHP should revisit its policy not to include prior allegations and disciplinary actions when giving the licensing boards files for allegation review.

6. BHP must resolve investigations and litigation in a timely manner. At a minimum, BHP must meet statutorily-mandated timelines.

Conclusion

Many citizens of Michigan, legislators, and even state employees charged with oversight would prefer to ignore the abortion industry in Michigan. The practices of those who profit from abortion shock the sensibilities. The appalling patient endangerment, heinous medical waste disposal practices, and persistent evasion of the law are deeply disturbing. These illegal and unethical activities have persisted unchecked for decades, and that fact is a source of shame for all of us.

Moving forward with vital reforms will require those charged with oversight and with lawmaking to face the realities of the abortion industry. The abuses must be addressed. Collaboration among the legislature, the Bureau of Health Systems, the Bureau of Health Professions, and the licensing boards can create a safer Michigan.

Appendix A

Alexander
#43-06-101901

BOARD REVIEW SHEET

Board Reviewer: The Department is requesting your review of the attached file. Pursuant to section 333.16231(2), if you believe that a violation of the Public Health Code has/may have occurred, please authorize this file for investigation.

____ **Unable to Authorize; Additional Information Needed**

_____

_____

_____

__✓__ **No Investigation Needed**
(No Violation of the Public Health Code)

Please indicate why you feel no investigation is needed:

Abortion is legal in the State of Michigan. Whether or not any person individual is agree with this is a personal matter between that person and his or her conscience. It does not change the law as it stands. There is no violation of the State Health Code. This file reflects an active campaign to discredit and prevent a physician from practicing because he chooses to follow his own conscience and the law and perform medical abortions

____ **Investigation Authorized**

Specific Public Health Code or rule violations you would like investigated:

_____

_____

_____

_____

_____

_____

_____

_____

(attach additional pages if needed)

George Shadid, MD
Printed Name

George N. Shadid 6/21/06
Signature Date

Rev: June 2006