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

In the Matter of

ALEX PICKENS, M.D.
License No. 43-01-038348
/

Complaint No. 43-16-139841
(consolidated with 43-15-137756)

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Michele M. Wagner-Gutkowski, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against (Respondent) alleging upon information and belief as follows:

Jurisdictional Allegations

1. The Board of Medicine, an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq*, is empowered to discipline licensees under the Code through its disciplinary subcommittee.

2. Respondent is currently licensed to practice medicine pursuant to the Public Health Code. He primarily practices obstetrics and gynecology and is affiliated with Sinai-Grace Hospital located in Detroit, Michigan.

3. Section 16221(a) of the Code provides the disciplinary subcommittee with authority to take disciplinary action against Respondent for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or

not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice medicine.

4. Section 16221(b)(i) of the Code provides the disciplinary subcommittee with authority to take disciplinary action against Respondent for incompetence, defined at section 16106(1) of the Code to mean: "[A] departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession whether or not actual injury to an individual occurs.

5. Section 16226 of the Code authorizes the disciplinary subcommittee to impose sanctions against persons licensed by the Board, if after opportunity for hearing, the disciplinary subcommittee determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

FACTUAL ALLEGATIONS

Patient W.P.

6. From August 2001 through December 12, 2013, Respondent provided gynecological and diabetic care to W.P. (initials used to protect patient confidentiality), an adult female.

7. On December 12, 2013, Respondent performed a total abdominal hysterectomy on patient W.P., to address fibroid uterus adenomas. Her history was positive for 3 cesarean section deliveries and prior pelvic surgery. In his operative report, Respondent noted W.P. had extensive adhesions extending from the rectum, pelvis, and sidewall.

8. Despite W.P.'s surgical history, Respondent used a bovie (an electrical cautery tool) when performing the hysterectomy to open the fascia and cut adhesions that contained bowel. Specifically, the operative report noted: "[t]he fascia was extended up and down with the bovie ...the rectal (sic) muscles were not able to be visualized as well. ...Bowel was noted as well as adhesions were noted in the omentum to the abdominal wall and they were taken down with the bovie." Respondent failed to obtain a surgical consult during the surgery.

9. On the second day of postoperative care, W.P.'s wound appeared to be separating. Although Respondent inspected the wound and had a pad placed over incision, he failed to document his assessment of the site.

10. On W.P.'s third day of postoperative care, she was noted to have had a spiked fever overnight, complaints of nausea without vomiting, and drainage from the incision. At 1:15 pm, W.P. had a syncopal episode. Respondent assessed W.P. at 4:44 pm and noted "doubt wound separation/closed c PDS II." Later in the evening, a resident informed Respondent that W.P.'s incision was draining material that looked like feces. Respondent instructed the resident to order a CT scan and start W.P. on antibiotics.

11. At 6:00 am on the fourth day following surgery (December 16, 2013), Respondent's resident entered a routine order for a general surgery consult rather than requesting the consult stat.

12. On December 16, 2013, at approximately 5:00 pm, general surgeon John Barnwell, M.D. assessed W.P. He took W.P. for exploratory laparotomy and

bowel resection surgery later that evening. During the surgery, Dr. Barnwell observed W.P. had an extensive amount of adhesions warranting consultation with a surgeon during the initial hysterectomy surgery.

Patient B.S.

13. On December 31, 2014, Patient B.S. presented to Summit Medical Center, located in Detroit, Michigan, for termination of pregnancy. She was approximately 16 weeks gestation. During the course of the procedure, B.S.'s uterine membrane spontaneously ruptured prior to her cervix being fully dilated. B.S. was transferred by ambulance to Sinai-Grace Hospital's emergency department.

14. Upon B.S.'s admission to Sinai-Grace, Respondent was asked to provide consultation and treatment to B.S. Respondent attempted dilation and evacuation, and performed cystoscopy, diagnostic laparoscopy, exploratory laparotomy, repair of cystotomy by urology team, repair of right round ligament laceration, hysterotomy and removal of retained products of conception.

15. Prior to performing the dilation and evacuation, Respondent failed to ensure B.S.'s bladder was emptied resulting in injury to B.S.'s urinary bladder.

COUNT I

16. Respondent's conduct as described above constitutes negligence and/or a failure to exercise due care, in violation of section 16221(a) of the Code.

COUNT II

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

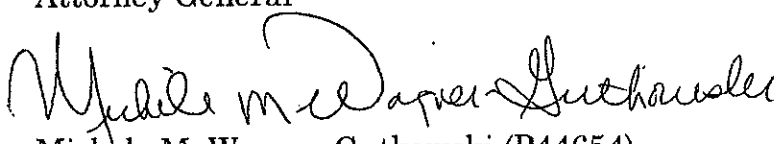
THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced pursuant to the Public Health Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*.

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

transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully Submitted,

BILL SCHUETTE
Attorney General



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