

Harvey Roth, MD  
9593 Parkview Avenue  
Boca Raton, FL 33428

September 23, 2019

RE: Administrative Complaint 43-19-001424

Matthew Wiersma  
Bureau of Professional Licensing  
Department of Licensing and Regulatory Affairs  
611 W. Ottawa  
P.O. Box 30670  
Lansing, Michigan 48909

RECEIVED  
SEP 27 2019  
DEPARTMENT OF LICENSING & REGULATORY AFFAIRS  
BUREAU OF PROFESSIONAL LICENSING  
ENFORCEMENT DIVISION

Dear Mr. Wiersma,

I am in receipt of the above listed Administrative Complaint. First and foremost, I would like to apologize for not forwarding the required information to your office in a timely fashion. I never meant any disrespect or disregard to the Bureau of Professional Licensing or the Michigan Board of Medicine. I look forward to your review of the information that I have sent and to the compliance conference that I have chosen.

Included with this correspondence are copies of the Florida Administrative Complaint (#2017-23375) and the Final Order. Also, I have included copies of my responses to the initial investigation (dated February 15, 2018) and rebuttal to the investigation (dated October 2, 2018). I hope these documents will provide insight as to what transpired and what corrective actions were immediately placed.

Just prior to the release of the Final Order, on July 8, 2019, I was in a serious highway automobile accident during which my car was totaled by another driver who was at fault. That incident took significant time to resolve.

Also, I have been so focused on addressing the issue in Florida, including completing the requirements of the Final Order that I was remiss in my responsibility to notify your office.

It is my hope that my issues with your office can be resolved quickly and without significant consequences.

Please let me know what my next step with your office is. Again, please accept my most sincere apologies to your office.

Warmest Regards,



Harvey Roth, MD  
License #4301-076768



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

RECEIVED  
SEP 27 2019  
DEPARTMENT OF LICENSING & REGULATORY AFFAIRS  
BUREAU OF PROFESSIONAL LICENSING  
ENFORCEMENT DIVISION  
ORLENE HAWKS  
DIRECTOR

COMPLIANCE CONFERENCE REQUEST

Please note: If you do not desire a compliance conference in person or by telephone, completion of this form is NOT required.

Even if you complete and return this form, you still MUST submit a WRITTEN response to the Administrative Complaint.

Name: Harvey Roth File Number: 43-19-001424  
Address: 9593 Parkview Avenue  
Boon Raton FL 33428  
Preferred Contact Number(s): (561) MCL 15.243(1)(a) Best time/day to call Mornings (before 10<sup>30</sup>am)

These days are preferable for me: (Please check all that apply)

☒ M

☒ T

☒ W

☒ Th

☒ F

I prefer:

☒ AM

☐ PM

I will appear:

☐ In person in Lansing

☒ Via Telephone

Additional comments regarding available dates:

Return address: Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing  
Regulation Section  
611 W. Ottawa Street  
P.O. Box 30670  
Lansing, MI 48909-8170

BUREAU OF PROFESSIONAL LICENSING  
611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909  
www.michigan.gov/bpl • 517-241-0199  
LARA is an equal opportunity employer/program

MW  
43-19-001424

*Handwritten signature/initials*

Final Order No. DOH-19-1214- **S** -MQA

FILED DATE - **JUL 22 2019**  
Department of Health

By: *[Signature]*

**Deputy Agency Clerk**

STATE OF FLORIDA  
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2017-23375  
LICENSE NO.: ME0064837

HARVEY CRAIG ROTH, M.D.,

Respondent.

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on June 7, 2019, in Miami, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise full advised in the premises, the Board rejected the Settlement Agreement and offered a Counter Settlement Agreement which Respondent was given 7 days to accept. By email dated July 17, 2019, the Respondent timely accepted the Board's Counter Settlement Agreement. The Counter Settlement Agreement incorporates the original Settlement Agreement with the following amendments:

1. The fine set forth in Paragraph 2 of the Stipulated Disposition shall be increased to \$10,000.00.

2. The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at \$3,563.70.

3. The lecture required by Paragraph 4 of the Stipulated Disposition shall include information regarding the performance of the appropriate time-out during surgical procedures.

4. Respondent shall document completion of a Board-approved laws and rules course within one year from the date the Final Order is filed.

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the amendments set forth above. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as amended.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 18<sup>th</sup> day of July, 2019.

BOARD OF MEDICINE

Claudia Kemp  
Claudia Kemp, J.D., Executive Director  
For Steven Rosenberg, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to HARVEY CRAIG ROTH, M.D., 20423 State Road 7 F6-199, Boca Raton, Florida 33498; Megan S. Paranzino, Esquire, Lubell Rosen, 200 South Andrews Avenue, Suite 900. Fort Lauderdale, Florida 33301; by email to Allison Dudley, Assistant General Counsel, Department of Health, at Allison.Dudley@flhealth.gov; and by email to Edward A. Tellechea, Chief Assistant Attorney General, at Ed.Tellechea@myfloridalegal.com this 22 day of July, 2019.

Angel Sanders

Deputy Agency Clerk

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**Petitioner,**

**v.**

**DOH Case No. 2017-23375**

**HARVEY CRAIG ROTH, M.D.,**

**Respondent.**

---

**SETTLEMENT AGREEMENT**

Harvey Craig Roth, M.D. (Respondent), and the Florida Department of Health (the Department), hereby stipulate and agree to the entry of a Final Order of the Florida Board of Medicine (the Board), incorporating the following agreed terms in settlement of the above-styled and numbered matter.

**STIPULATED FACTS**

1. The Department is the state agency charged with regulating the practice of medicine in the state of Florida pursuant to section 20.43, Florida Statutes, and chapters 456 and 458, Florida Statutes.
  2. At all times material hereto, Respondent was a licensed physician in Florida, having been issued license number ME 64837.
  3. The Department filed and properly served upon Respondent an Administrative Complaint which charged him with a violation of chapter 456, Florida Statutes. A true and correct copy of the Administrative Complaint is attached hereto as Exhibit A.
-

4. For purposes of these proceedings, Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

**STIPULATED CONCLUSIONS OF LAW**

1. Respondent admits that, in his capacity as a Florida-licensed physician, he is subject to the provisions of chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts alleged in the Administrative Complaint, if proven, would constitute a violation of chapter 456, Florida Statutes.

3. Respondent agrees that the Stipulated Disposition in this case is fair, appropriate, and acceptable to Respondent.

**STIPULATED DISPOSITION**

1. **Letter of Concern** - The Board shall issue a Letter of Concern against Respondent's license.

2. **Fine** - The Board shall impose an administrative fine of *Three Thousand Dollars and Zero Cents (\$3,000.00)* against Respondent's license which Respondent shall pay to: Payments, Department of Health, Compliance Management Unit, Bin C-76, P.O. Box 6320, Tallahassee, Florida 32314-6320, within thirty (30) days of the date of the filing of the Final Order accepting this Agreement (the Final Order). All fines shall be paid by cashier's check or money order. Any change in the terms of payment of any fine imposed by the Board must be approved in advance by the Board's Probation Committee.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED IN THIS AGREEMENT. SPECIFICALLY, IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION WITHIN FORTY-FIVE (45) DAYS FROM THE DATE THE FINAL ORDER IS FILED THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL RESPONDENT RECEIVES SUCH WRITTEN CONFIRMATION FROM THE BOARD.

3. Reimbursement of Costs - Pursuant to section 456.072, Florida Statutes, Respondent agrees to pay the Department for the Department's costs incurred in the investigation and prosecution of this case. Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, any other costs Respondent incurs to comply with the Final Order, and the Board's administrative costs directly associated with Respondent's probation, if any. Respondent agrees that the amount of costs to be paid in this case is currently *Two Thousand Two Hundred Twenty-One Dollars and Eighty-Four Cents (\$2,221.84)*, but shall not exceed *Four Thousand Two Hundred Twenty-One Dollars and Eighty-Four Cents (\$4,221.84)*. Respondent will pay such costs to: Payments, Department of Health, Compliance Management Unit, Bln C-76, P.O. Box 6320, Tallahassee, Florida 32314-6320, within thirty (30) days from the date the Final Order is filed. All costs shall be paid by cashier's check or money order. Any change in the terms of payment of costs imposed by the Board must be approved in advance by the Board's Probation Committee.



**RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED IN THIS AGREEMENT. SPECIFICALLY, IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION WITHIN FORTY-FIVE (45) DAYS OF THE DATE THE FINAL ORDER IS FILED THAT THE FULL AMOUNT OF THE COSTS HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL RESPONDENT RECEIVES SUCH WRITTEN CONFIRMATION FROM THE BOARD.**

4. Lecture/Seminar - Within six (6) months from the date the Final Order is filed, Respondent shall present a one (1) hour lecture/seminar in the area of "risk management and avoiding wrong procedures in the office surgery setting," to medical staff at an approved medical facility. Respondent shall submit a written plan to the Board's Probation Committee for approval prior to performance of said lecture/seminar. Within six (6) months from the date the Final Order is filed, Respondent shall obtain a letter from the Risk Manager of the approved medical facility indicating that the lecture/seminar has been completed and submit such letter to the Board's Probation Committee.

5. Continuing Medical Education - "Risk Management" - Respondent shall document completion of this requirement within one (1) year from the date the Final Order is filed. Respondent shall satisfy this requirement in one of the two following ways:

a. Respondent shall complete five (5) hours of Continuing Medical Education (CME) in "Risk Management" after first obtaining written advance approval from the Board's Probation Committee of such proposed course, and shall submit documentation of such completion, in the form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee; or

b. Respondent shall complete five (5) hours of CME in "Risk Management" by attending one full day or eight (8) hours, whichever is more, of disciplinary hearings at a regular meeting of the Board. In order to receive such credit, Respondent must sign in with the Executive Director of the Board before the meeting day begins, Respondent must remain in continuous attendance during the full day or eight (8) hours of disciplinary hearings, whichever is more, and Respondent must sign out with the Executive Director of the Board at the end of the meeting day or at such other earlier time as affirmatively authorized by the Board. Respondent may not receive CME credit in risk management for attending the disciplinary hearings portion of a Board meeting unless the Respondent is attending the disciplinary hearings portion for the sole purpose of obtaining the CME credit in "Risk Management." In other words, Respondent may not receive such credit if appearing at the Board meeting for any other purpose, such as pending action against Respondent's medical license.

#### **STANDARD PROVISIONS**

1. **Appearance** - Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

2. No Force or Effect until Final Order - It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless the Board enters a Final Order incorporating the terms of this Agreement.

3. Continuing Medical Education - Unless otherwise provided in this Agreement, Respondent shall first submit a written request to the Board's Probation Committee for approval prior to performance of said CME course(s). Respondent shall submit documentation to the Board's Probation Committee of having completed a CME course in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year from the date the Final Order is filed. All such documentation shall be sent to the Board's Probation Committee, regardless of whether some or any of such documentation was provided previously during the course of any audit or discussion with counsel for the Department. CME hours required by this Agreement shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board's Probation Committee, such CME course(s) shall consist of a formal, live lecture format.

4. Addresses - Respondent must provide current residence and practice addresses to the Board. Respondent shall notify the Board in writing within ten (10) days of any changes of said addresses.

5. Future Conduct - In the future, Respondent shall not violate chapter 456, 458, or 893, Florida Statutes, or the rules promulgated pursuant thereto, or any other

state or federal law, rule, or regulation relating to the practice or the ability to practice medicine to include, but not limited to, all statutory requirements related to practitioner profile and licensure renewal updates. Prior to signing this Agreement, Respondent shall read chapters 456, 458, and 893, Florida Statutes, and the rules of the Board, at chapter 64B8, Florida Administrative Code.

6. Violation of Terms - It is expressly understood that a violation of the terms of this Agreement shall be considered a violation of a Final Order of the Board, for which disciplinary action may be initiated pursuant to chapters 456 and 458, Florida Statutes.

7. Purpose of Agreement - Respondent, for the purpose of avoiding further administrative action with respect to this cause, executes this Agreement. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of this Agreement. Respondent agrees to support this Agreement at the time it is presented to the Board and shall offer no evidence, testimony, or argument that disputes or contravenes any stipulated fact or conclusion of law. Furthermore, should this Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration, or resolution of these proceedings.

8. No Preclusion of Additional Proceedings - Respondent and the Department fully understand that this Agreement and subsequent Final Order will in no

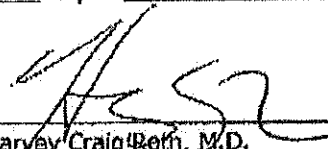
way preclude additional proceedings by the Board and/or the Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached hereto as Exhibit A.

9. Waiver of Attorney's Fees and Costs - Upon the Board's adoption of this Agreement, the parties hereby agree that, with the exception of Department costs noted above, the parties will bear their own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Department and the Board in connection with this matter.

10. Waiver of Further Procedural Steps - Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of this Agreement and the Final Order of the Board incorporating this Agreement.

*[Signatures appear on the following page.]*

SIGNED this 6 day of March, 2019.

  
Harvey Craig Roth, M.D.

STATE OF FLORIDA

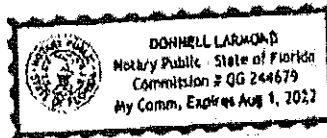
COUNTY OF Broward

BEFORE ME personally appeared Harvey Roth, whose identity is known to me or who produced [REDACTED] (type of identification) and who, under oath, acknowledges that his signature appears above.

SWORN TO and subscribed before me this 6 day of 2019 March, 2019.

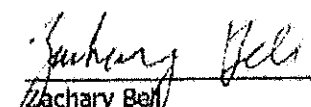
  
NOTARY PUBLIC

My Commission Expires:



APPROVED this 12<sup>th</sup> day of March, 2019.

By:

  
Zachary Bell  
Assistant General Counsel  
Department of Health

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.**

**CASE NO. 2017-23375**

**HARVEY CRAIG ROTH, M.D.,**

**RESPONDENT.**

---

**ADMINISTRATIVE COMPLAINT**

Petitioner, Department of Health, files this Administrative Complaint before the Board of Medicine against Respondent, Harvey Craig Roth, M.D., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.
  2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 64837.
  3. Respondent's address of record is: 20423 State Road 7, Suite F6-199, Boca Raton, Florida 33498.
-

4. Respondent is board certified by the American Board of Obstetrics and Gynecology, in the field of obstetrics and gynecology.

5. On or about December 11, 2017, Patient K.M., then a thirty-five (35) year old female, presented to Respondent at A Woman's Center of Hollywood, 3829 West Hollywood Boulevard, Suite C, Hollywood, Florida 33021, for a medical termination of her pregnancy (the correct procedure).

6. On or about December 11, 2017, Patient S.H. provided informed consent for the medical termination of her pregnancy.

7. On or about December 11, 2017, Respondent performed a surgical termination of pregnancy procedure on Patient K.M. (the wrong procedure), instead of assisting Patient K.M. with a medical termination of her pregnancy.

8. Patient K.M. did not authorize Respondent to perform a surgical termination of pregnancy procedure on her prior to Respondent's performance of the surgical termination of pregnancy procedure.

9. Section 456.072(1)(bb), Florida Statutes (2017), provides that performing or attempting to perform health care services (including the preparation of the patient) on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is



medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition is grounds for disciplinary action by the Board of Medicine.

10. Respondent performed a wrong procedure and/or an unauthorized procedure when he performed a surgical termination of pregnancy procedure on Patient K.M., instead of assisting her in a medical termination of her pregnancy.

11. Based on the foregoing, Respondent violated section 456.072(1)(bb), Florida Statutes (2017), by performing a wrong procedure and/or unauthorized procedure on Patient K.M., by performing an unauthorized surgical termination of pregnancy procedure on Patient K.M. Instead of assisting Patient K.M. with a medical termination of her pregnancy.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

*[Signature appears on the following page.]*

SIGNED this 3<sup>rd</sup> day of January, 2019.

Celeste Phillip, MD, MPH  
State Surgeon General

Corynn Alberto

for

Zachary Bell 68814  
Assistant General Counsel  
Florida Bar No. 0105735  
DOH-Prosecution Services Unit  
4052 Bald Cypress Way-Bin C-65  
(850) 245-4666  
(850) 245-4684 fax  
E-Mail: zachary.bell@flhealth.gov

FILED  
DEPARTMENT OF HEALTH  
DEPUTY CLERK

CLERK: Angela Sanders  
DATE: JAN 03 2019

ZB

PCP: December 28, 2018.

PCP Members: Georges El-Bahri, M.D.; Seela Ramesh, M.D.;  
Nicholas Romanello

## **NOTICE OF RIGHTS**

**Respondent has the right to request a hearing to be conducted in accordance with section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to rule 28-106.2015(5), Florida Administrative Code.**

**Please be advised that mediation under section 120.573, Florida Statutes, is not available for administrative disputes involving this agency action.**

## **NOTICE REGARDING ASSESSMENT OF COSTS**

**Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition any other discipline imposed.**

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.**

**CASE NO. 2017-23375**

**HARVEY CRAIG ROTH, M.D.,**

**RESPONDENT.**

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1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 64837.

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*[Signature appears on the following page.]*

SIGNED this 3<sup>rd</sup> day of January, 2019.

Celeste Philip, MD, MPH  
State Surgeon General

*for* Corynne Alberto  
Zachary Bell 68814  
Assistant General Counsel  
Florida Bar No. 0105735  
DOH-Prosecution Services Unit  
4052 Bald Cypress Way-Bin C-65  
(850) 245-4666  
(850) 245-4684 fax  
E-Mail: zachary.bell@flhealth.gov

FILED  
DEPARTMENT OF HEALTH  
DEPUTY CLERK

CLERK: *Angel Sanders*  
DATE: **JAN 03 2019**

ZB

PCP: December 28, 2018.

PCP Members: Georges El-Bahri, M.D.; Seela Ramesh, M.D.;  
Nicholas Romanello

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LUBELL | ROSEN

Museum Plaza  
Suite 900  
200 South Andrews Avenue  
Fort Lauderdale, FL 33301

[www.lubellrosen.com](http://www.lubellrosen.com)

Megan S. Paranzino, Esq.

(954) 880-9500 office  
(954) 755-2993 fax  
[msp@lubellrosen.com](mailto:msp@lubellrosen.com)

February 15, 2018

**VIA EMAIL & U.S. MAIL**

Katherine F. Rosenblatt, M.S.  
Florida Department of Health  
Division of Medical Quality Assurance - Bureau of Enforcement  
1400 West Commercial Blvd  
Suite 130  
Fort Lauderdale, FL 33309  
Email: [katherine.rosenblatt@flhealth.gov](mailto:katherine.rosenblatt@flhealth.gov)

RE: Harvey C. Roth, M.D.  
Case No.: 2017 23376  
Our File No: 2832-5

Dear Ms. Rosenblatt:

As you know, this firm represents Harvey Craig Roth, M.D. in the above referenced matter. We are in receipt of the Department's January 4, 2018 letter to Dr. Roth explaining the investigation against him. See enclosed as Exhibit "A". Please accept this letter as Dr. Roth's formal response to the complaint. A copy of Dr. Roth's most recent curriculum vitae is enclosed as Exhibit "B".

The Complaint alleges that Dr. Roth possibly violated Florida Statute 458.331(1)(g)(m)(t)(nn), Florida Statute 456.072(1)(k)(bb)(dd), and Rule 64B8-9.003, F.A.C. by allegedly practicing below the standard of care, performing the wrong unauthorized procedure, failing to maintain adequate records, and failing to perform a statutory/legal obligation. Specifically, the Complainant, patient K.M., alleges that Dr. Roth rendered "substandard care" by performing a surgical abortion rather than a medical abortion. Further, she alleges that Dr. Roth failed to maintain records.

**Introduction**

Dr. Roth is a Board-Certified physician specializing in Obstetrics and Gynecology and family medicine. Dr. Roth has practiced medicine in the State of Florida since 1995. A portion of Dr. Roth's professional practice includes treating patients at A Women's Center of Hollywood. Dr.

Roth rendered care and treatment to K.M. at A Women's Center of Hollywood (hereinafter "the clinic").

Dr. Roth regrets that patient K.M. underwent a surgical termination of pregnancy rather than a medical termination of pregnancy which she desired and consented to. Fortunately, K.M. did not suffer from any complications and her intended outcome was achieved. Nevertheless, Dr. Roth acknowledges that he unknowingly performed the wrong procedure and has implemented changes in his practice to prevent a similar occurrence going forward. Dr. Roth condemns the actions of the clinic's staff members who attempted to destroy and discard part of the patient's medical record. This was done without Dr. Roth's knowledge. When Dr. Roth learned of their actions, he immediately instructed the clinic to retrieve the discarded records. But for Dr. Roth's instruction and insistence, the discarded records would not have been recovered.

#### Dr. Roth's Affiliation with A Women's Center of Hollywood

A Women's Center of Hollywood is a licensed abortion clinic in Hollywood, Florida. Dr. Roth is an independent contractor at A Women's Center of Hollywood and has no ownership interest. He typically works three days per week totaling three to five hours per week at the clinic. Dr. Roth is not the medical director of A Women's Center of Hollywood nor is he the medical records custodian. Dr. Roth always completely and accurately authors medical records to reflect his care and treatment of the clinic's patients. Dr. Roth relies on the clinic to maintain and store the clinical records, as they are required to do under Florida Administrative Code 59A-9.031.

#### Medical Care and Treatment of Patient, K.M.

##### *Part I – Initial interactions with the clinic and its staff, per K.M.'s Complaint.*

K.M.'s Complaint concerns events which transpired on December 11, 2017 when she presented to the clinic as a walk-in patient. Upon arrival, she was greeted by the receptionist and requested the "Abortion Pill." K.M. completed paperwork and a consent form for a medical termination of pregnancy. Shortly thereafter, she went to an exam room and a medical assistant took her vitals. The medical assistant discussed the pill schedule and the risks and complications. The medical assistant advised that she would need a vaginal ultrasound. K.M. then went into another waiting room to wait for an ultrasound.

##### *Part II – Dr. Roth's care and treatment of K.M.*

At this time, Dr. Roth reviewed the clinical chart for his next patient. The patient's first name was Ashley. Ashley's chart reflected that she presented for a surgical termination of pregnancy. The medical assistant, Miriam, went into the waiting room and called out for patient "Ashley" to come to the back. A patient stood up, presumably "Ashley", and Miriam brought her into the ultrasound room. Today, we know that the patient was not Ashley, rather it was K.M.

Pursuant to his custom and routine, Dr. Roth reviewed the chart and learned the patient's first name and the intended course of treatment before meeting her. As the patient entered the room, Dr. Roth greeted her by her first name, "Ashley". K.M. did not correct him. Next, Dr. Roth asked the patient to sit on the end of the table and put her feet into the footrests. Pursuant to his custom and routine, Dr. Roth addressed the patient by her first name, "Ashley" for the second time and asked if she had any questions about "anything you have been told or anything we are going to do." K.M. did not correct Dr. Roth or question him calling her by the wrong name.

Dr. Roth performed the ultrasound and informed the patient of the gestational age, which was approximately five weeks. Dr. Roth showed the patient the gestational sac and advised that there was no fetus visible on ultrasound. Dr. Roth does not recall the patient being visibly distraught or in tears. It is not uncommon for Dr. Roth to encounter patients who are mentally distraught and when that happens, he is careful to ensure that the patient wishes to proceed with the termination before moving forward. Dr. Roth feels that it is an elective procedure and the patient should wait at least 24-hours in the event of uncertainty.

Dr. Roth was acting under the belief he was treating patient "Ashley" for her requested surgical termination of pregnancy. Pursuant to his custom and routine, he addressed the patient by her first name for the third time. He asked, "Ashley, do you have any medical problems? Do you smoke, drink, or use drugs?" K.M. answered "no" to both questions and did not correct Dr. Roth when he continued to call her the wrong name.

Dr. Roth had no reason to believe that he was treating K.M. as K.M. continuously responded to the name "Ashley". Dr. Roth then placed an IV and administered conscious sedation (Midazolam and meperidine). Dr. Roth counseled the patient to relax and take deep breaths through her nose and out her mouth. K.M. still did not question the treatment. The conscious sedation relaxed the patient and she remained able to answer questions and follow instructions and commands. K.M. may not recall what transpired during the procedure, however she was not "asleep". Dr. Roth performed the surgical termination without any medical issues or complications.

Dr. Roth learned of the mistake when K.M. was taken to recovery. A staff member of the clinic informed him and the medical assistant, Miriam, that K.M. was there for a medical termination of pregnancy, not a surgical termination of pregnancy. Dr. Roth showed the staff member Ashley's chart and the staff member advised him that it was the incorrect chart for the patient.

Dr. Roth immediately endeavored to rectify the situation. As K.M. recovered, Dr. Roth went to check on her. Dr. Roth immediately apologized for the error and twice explained to her what had happened. K.M. seemed to recall the events and was most concerned about whether she would be alright. Dr. Roth informed her she would be fine. K.M. had received Midazolam which can cause amnesia and it appears she does not recall the two discussions.

Importantly, Dr. Roth documented his care and treatment, including the mistake, in K.M.'s chart. Dr. Roth ensured that K.M.'s records which were initially documented in Ashley's chart

were transferred to K.M.'s chart. Dr. Roth spoke with the clinic staff to explain what happened and told the staff to let him know if there were any questions.

The following day, the clinic contacted Dr. Roth and advised him that K.M. was in the office demanding her chart. Dr. Roth instructed the clinic staff member to provide the complete chart immediately, including the documentation on the medical termination of pregnancy sheet stating what had occurred. The staff member informed Dr. Roth that the medical termination of pregnancy information was not in K.M.'s chart. Dr. Roth was shocked and displeased to learn that the clinic apparently tampered with K.M.'s medical chart.

Dr. Roth demanded to speak with the owner/administrator of the clinic. The owner/administrator advised Dr. Roth that his medical charting was discarded from K.M.'s chart. Dr. Roth informed the owner/administrator that it is unethical and illegal to destroy medical records. The owner/administrator responded that the trash had not been put out for pick up yet. Dr. Roth directed the clinic to immediately search the trash for the missing records. Fortunately, the clinic located the torn-up missing records. Dr. Roth directed the clinic to save the torn-up records and return them to K.M.'s chart.

#### The Clinic's Duty to Maintain Records

As stated above, Dr. Roth is an independent contractor who works at the clinic from three to five hours per week. He is not the records custodian for the clinic. He does not control how the clinic maintains or stores the clinic's patient's charts. Pursuant to Florida Administrative Code 59A-9.031, the abortion clinic is responsible for securing and storing the clinical records of each clinic patient, not him. Dr. Roth relies on the clinic to fulfill their duty to secure and store clinical records. Of course, Dr. Roth has a duty to document his medical care in the clinical chart and he fulfilled that duty to patient K.M.

Unbeknownst to Dr. Roth, the clinic altered the patient's medical records and attempted to destroy medical documentation. Fortunately, Dr. Roth discovered this prior to the torn-up records leaving the facility site. But for Dr. Roth's direction and insistence, K.M.'s records would not have been recovered.

As for the altered records, Dr. Roth had no knowledge that the clinic intended to prepare new records to coincide with the medical termination of pregnancy that was performed on this patient. Notably, Dr. Roth's signature and writing do not appear on any of the records generated by the clinic because of the surgical termination of pregnancy procedure.

#### Subsequent Procedures for Identifying Patients

Dr. Roth implemented changes to his personal practice to prevent this from occurring again. He no longer addresses the patient by their first name and relies on the patient to correct him if the wrong name is used. Instead, he asks the patient to identify herself by first and last



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October 2, 2018

**VIA EMAIL & FACSIMILE**

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Florida Department of Health  
Office of the General Counsel – Prosecution Services Unit  
4052 Bald Cypress Way, Bin C-65  
Tallahassee, FL 32399-3265  
Fax: 850-245-4684

RE: Harvey C. Roth, M.D.  
Case No.: 2017 23376  
Our File No: 2832-5

Dear Mr. Bell:

This firm represents Harvey C. Roth, M.D. in the above referenced matter. We are in receipt of the Department's September 13, 2018 letter and the enclosed Investigative File. Please accept this as Dr. Roth's response to the Investigative File. Enclosed for convenience is a copy of Dr. Roth's February 15, 2018 response to the Complaint.

Dr. Roth is a Board-Certified physician specializing in Obstetrics and Gynecology and family medicine. Dr. Roth rendered care and treatment to K.M. at A Women's Center of Hollywood (hereinafter "the clinic").

Dr. Roth has a very clear and distinct recollection of his treatment of K.M. due to the unusual events that occurred. He regrets that K.M. underwent a surgical termination of pregnancy rather than a medical termination of pregnancy which she desired and consented to. However, Dr. Roth disagrees with K.M.'s descriptions of the events, Dr. Roth's demeanor, and Dr. Roth's actions.

*Response to Interview of K.M.*

The first paragraph in the "INTERVIEW OF K.N.M. (Source)" does not concern Dr. Roth's care and treatment. Accordingly, Dr. Roth does not have any comment on this paragraph.

Dr. Roth's treatment is discussed beginning in the third sentence of the second paragraph. K.M. stated that Dr. Roth did not introduce himself, speak with her or look at her directly. This is simply false. Dr. Roth introduced himself and conversed with K.M. throughout her appointment. As stated in the response to the Complaint, when the patient entered the room, Dr. Roth greeted her by her first name, "Ashley" and K.M. did not correct him. Dr. Roth denies that she was crying or exhibiting other visible signs of being distraught.

Next, Dr. Roth asked the patient to sit on the end of the table and put her feet into the footrests. The patient's perception of "frustration in Dr. Roth's eyes" is wrong. Dr. Roth was not frustrated with the patient at that point or during any other time of the treatment. Dr. Roth continued to address the patient as "Ashley" and asked if she had any questions about "anything you have been told or anything we are going to do." K.M. did not correct Dr. Roth or question him calling her by the wrong name.

Dr. Roth performed the ultrasound and informed the patient of the gestational age, which was approximately five weeks. Dr. Roth showed the patient the gestational sac and advised that there was no fetus visible on ultrasound. There was no fetus because she was so early in her pregnancy.

Dr. Roth does not recall the patient being visibly distraught or crying. It is not uncommon for Dr. Roth to encounter patients who are mentally distraught and when that happens, he is careful to ensure that the patient wishes to proceed with the termination before moving forward. Dr. Roth feels that it is an elective procedure and the patient should wait at least 24-hours in the event of uncertainty.

Dr. Roth was acting under the belief he was treating patient "Ashley" for her requested surgical termination of pregnancy. Pursuant to his custom and routine, he addressed the patient by her first name for the third time. He asked, "Ashley, do you have any medical problems? Do you smoke, drink, or use drugs?" K.M. answered "no" to both questions and did not correct Dr. Roth when he continued to call her the wrong name.

Dr. Roth had no reason to believe that he was treating K.M. as she continuously responded to the name "Ashley". Dr. Roth then placed an IV and used the IV to administer conscious sedation (Midazolam and meperidine). Dr. Roth counseled the patient to relax and take deep breaths through her nose and out her mouth. K.M. still did not question the treatment. The conscious sedation relaxed the patient and she remained able to answer questions and follow instructions and commands. K.M. may not recall what transpired during the procedure, however she was not "asleep." Dr. Roth performed the surgical termination without any medical issues or complications.

Dr. Roth learned of the mistake when K.M. was taken to recovery. A staff member of the clinic informed him and the medical assistant that K.M. was there for a medical termination of pregnancy, not a surgical termination of pregnancy. Dr. Roth showed the staff member Ashley's chart and the staff member advised him that it was the incorrect chart for the patient.

Dr. Roth immediately attempted to rectify the situation. As K.M. recovered, Dr. Roth went to check on her. Dr. Roth apologized for the error and twice explained to her what had happened. K.M. seemed to recall the events and was most concerned about whether she would be alright. Dr. Roth informed her she would be fine. K.M. had received Midazolam which can cause amnesia and it appears she does not recall the two discussions.

Importantly, Dr. Roth documented his care and treatment, including the mistake, in K.M.'s chart. Dr. Roth spoke with the clinic staff to explain what happened and told the staff to let him know if there were any questions. Dr. Roth had no knowledge that the clinic intended to prepare

new records to coincide with the medical termination of pregnancy that was performed. Dr. Roth had no knowledge of the clinic's staff members instructing K.M. to complete additional paperwork and/or forms for the surgical abortion. He also had no knowledge of the clinic staff requiring her to sign documents before she could leave. Notably, Dr. Roth's signature and writing do not appear on any of the records generated by the clinic because of the surgical termination of pregnancy procedure.

#### *Consent Forms*

K.M. asserts that she did not consent to a surgical abortion and that the event was traumatic. Dr. Roth acknowledges that K.M. desired and consented to a medical abortion. Notably, not all medical abortions are successful and if a medical abortion fails, then the patient will need to undergo a surgical abortion. The medical abortion consent form addressed that risk and possibility. It is reasonable to believe that when K.M. decided to proceed with a medical abortion, she was aware that she may ultimately require a surgical abortion.

#### *The Clinic's Duty to Maintain Records*

Dr. Roth is an independent contractor who works at the clinic from three to five hours per week. He is not the records custodian and he does not control how the clinic maintains or stores the clinic's patient's charts. Pursuant to Florida Administrative Code 59A-9.031, the abortion clinic is responsible for securing and storing the clinical records of each clinic patient. Dr. Roth relies on the clinic to fulfill their duty. Of course, Dr. Roth has a duty to document his medical care in the clinical chart and he fulfilled that duty to patient K.M.

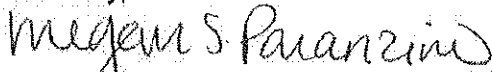
#### *Subsequent Procedures for Identifying Patients*

Dr. Roth implemented changes to his personal practice to prevent this from occurring again. He no longer addresses the patient by their first name and relies on the patient to correct him if the wrong name is used. Instead, he asks the patient to identify herself by first and last name upon entering the examination/surgical room. He then addresses the patient by name during his care and treatment.

#### *Conclusion*

On behalf of Dr. Roth, we thank you for your ongoing attention and careful consideration of this letter as part of the investigation. We respectfully request that you evaluate K.M.'s claim in light of this response. Should you have any questions or concerns, please do not hesitate to contact our office.

Sincerely,



Megan S. Paranzino, Esq.

Enclosures

Cc: Harvey Roth, M.D.



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