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

In the Matter of

J. GILBERTO HIGUERA, M.D. Complaint No. 43-01-1225-00
_____/ CONSENT ORDER AND STIPULATION

CONSENT ORDER

An Administrative Complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on June 25, 2001, charging J. Gilberto Higuera, M.D., (Respondent), with having violated sections 16221(b)(v) and (b)(viii) of the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 *et seq*; MSA 14.15(1101) *et seq*.

Respondent has admitted by Stipulation contained in this document that the facts alleged in the Complaint are true and constitute violation of the Public Health Code.

The Disciplinary Subcommittee has reviewed the Stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding Complaint.

Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the Complaint are true and constitute a violation of sections 16221(b)(v) and (b)(viii) of the Public Health Code.

Accordingly,

IT IS ORDERED that for each of the violations Respondent's license is REVOKED commencing on the effective date of this Order. The revocations shall run concurrently. This revocation shall run concurrently with the previous order of suspension entered on January 29, 1999, by which Respondent's license was suspended for six months and one day. (Complaint No. 43-94-5210-00.)

IT IS FURTHER ORDERED that Respondent shall pay the $5,000.00 fine imposed as part of the sanction in Complaint No. 43-94-5210-00 prior to filing his application for reinstatement. The payment of the fine shall be mailed to the Sanction Monitoring of Health Services, Department of Consumer & Industry Services, P.O. Box 30185, Lansing, Michigan 48909.

IT IS FURTHER ORDERED that should Respondent violate any term or condition set forth here, it may be determined that Respondent has violated an order of the Disciplinary Subcommittee, 1996 AACS, R 338.1632, and section 16221(g) of the Public Health Code.

IT IS FURTHER ORDERED that a petition for reinstatement may not be filed until three years after the effective date of the revocation.

IT IS FURTHER ORDERED that this Order shall be effective on the date signed by the Disciplinary Subcommittee or its authorized representative, as set forth below.

Signed this 19th day of Sept., 2001.

MICHIGAN BOARD OF MEDICINE

By: _____
Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate and agree as follows:

1. The allegations of fact contained in the Complaint are true and constitute a violation of sections 16221(b)(v) and (b)(viii) of the Public Health Code.

2. Respondent understands and intends that by signing this stipulation he is waiving the right pursuant to the Public Health Code, rules promulgated thereunder, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*; MSA 3.560(101) *et seq*, to require the State to prove the charges set forth in the Complaint by presentation of evidence and legal authority, and to appear with an attorney and such witnesses as Respondent may desire to present a defense to the charges before the Disciplinary Subcommittee or its authorized representative.

3. Respondent understands that reinstatement of the license at the end of the period of revocation is not automatic but that pursuant to sections 16245 and 16247 of the Public Health Code, and rules promulgated thereunder, a petition for reinstatement must be filed and Respondent must establish by clear and convincing evidence that he

is of good moral character, is able to practice the profession with reasonable skill and safety, and that it is in the public interest for the license to be reinstated.

4. The Board's conferee, Kenneth McNamee, M.D., who has indicated support of this proposal, and the undersigned Assistant Attorney General are free to discuss this matter with the Disciplinary Subcommittee and recommend acceptance of the resolution set forth in the Consent Order.

5. This Consent Order is approved by the respective parties and may be entered as the Final Order of the Disciplinary Subcommittee in this cause.

6. This proposal is conditioned upon its acceptance by the Disciplinary Subcommittee, the parties expressly reserving the right to further proceedings without prejudice should the Consent Order be rejected.

AGREED TO BY:

Merry A. Rosenberg (P32120)
Assistant Attorney General
Attorney for Complainant
Dated: 8/9/01

AGREED TO BY:

J. Gilberto Higuera, M.D.
Respondent

State of COLORADO)
)ss
County of EAGLE)

On the 23RD day of JULY, 2001, J. Gilberto Higuera, M.D., signed this Consent Order and Stipulation in front of me.

NOTARY PUBLIC DONNA JILK STATE OF COLORADO

Notary Public, EAGLE County
State of COLORADO
My commission expires: 12/15/2001

I have reviewed and approved the foregoing document ~~both~~ as to form ~~and substance~~.

Max R. Hoffman, Jr. (P23199)
Attorney for Respondent

This is the last and final page of a Consent Order and Stipulation in the matter of J. Gilberto Higuera, M.D., pending before the Disciplinary Subcommittee of the Michigan Board of Medicine, and consisting of five pages, this page included.

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

In the Matter of

J. GILBERTO HIGUERA, M.D.
_____/

Complaint No. 43-01-1225-00

ADMINISTRATIVE COMPLAINT

Attorney General Jennifer M. Granholm, through Assistant Attorney General Merry A. Rosenberg, on behalf of the Department of Consumer & Industry Services, Bureau of Health Services (Complainant), files this Complaint against J. Gilberto Higuera, M.D., (Respondent), alleging upon information and belief as follows:

1. The Board of Medicine (Board), an administrative agency established by the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 *et seq*; MSA 14.15(1101) *et seq*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee.

2. Respondent's license to practice medicine is currently suspended pursuant to a Final Order entered on January 29, 1999, based on findings that Respondent had violated sections 16221(a) and (b)(i) and (b)(vi) of the Public Health Code for reusing medical supplies between patients and sections 16221(a), (b)(i), and (b)(vi) for altering a patient's record. (Attachment 1)

3. Section 16221(b)(v) of the Public Health Code provides the Disciplinary Subcommittee with authority to take disciplinary action against Respondent's license for conviction of a felony. A certified copy of the court record is conclusive evidence of the conviction.

4. Section 16221(b)(viii) of the Public Health Code provides the Disciplinary Subcommittee with authority to take disciplinary action against Respondent's license for conviction of a violation of section 492a of the Michigan Penal Code, 1931 PA 328, MCL 750.492a. A certified copy of the court record is conclusive evidence of the conviction.

5. Section 16226 of the Public Health Code provides that the sanction for a violation of section 16221(b)(viii) is revocation.

6. On May 7, 2001, Respondent pled guilty to one count of altering a patient's record in violation of MCL 750.492a. (Attachment 2)

7. On May 30, 2001, Respondent was sentenced to probation for one year for this conviction. (Attachment 2)

COUNT I

8. The conduct described in paragraph 6 above constitutes conviction of a felony, in violation of section 16221(b)(v) of the Public Health Code.

COUNT II

9. The conduct described in paragraph 6 above constitutes a conviction of MCL 750.492a, which constitutes a violation of section 16221(b)(viii) of the Public Health Code.

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

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

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

Respondent's license shall remain suspended pursuant to the Final Order entered on January 29, 1999.

Respectfully submitted,

JENNIFER M. GRANHOLM
Attorney General

Merry A. Rosenberg
Assistant Attorney General
Health Professionals Division
P.O. Box 30217
Lansing, Michigan 48909
Tel: (517) 373-1146
Fax: (517) 241-1997

Date: June 25, 2001

Attachments
Tlk/mar01cases higuera P AC 6-25-01

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

In the Matter of

JOSE GILBERTO HIGUERA, M.D.
License Number: 43-01-028049

Complaint Number: 43-94-5210-00
Docket Number: 96-0616

FINAL ORDER

On July 22, 1996, the Department of Attorney General, Health Professionals Division, hereafter Health Professionals Division, filed an Administrative Complaint with the Disciplinary Subcommittee of the Michigan Board of Medicine, hereafter Disciplinary Subcommittee, charging Jose Gilberto Higuera, M.D., hereafter Respondent, with violations of sections 16221(a), 16221(b)(i), and 16221(b)(vi) of the Public Health Code, 1978 PA 368, as amended.

On December 17, 1996, Respondent filed a Motion for Stay of Proceedings, requesting a stay of the administrative proceedings pending resolution of criminal proceedings against Respondent which were based on the same conduct as alleged in the Administrative Complaint.

On January 2, 1997, the Health Professionals Division filed the State's Response to Motion for Stay of Proceedings and the State's Brief in Support of Response in Opposition to Respondent's Motion for Stay of Proceedings.

On January 10, 1997, the administrative law judge issued an Order Granting Partial Stay of Allegations, which ordered the hearing of allegations in paragraphs 7

ATTACHMENT 1

through 12 of Count I and paragraph 15 of Count II of the Administrative Complaint stayed. It was also ordered that the hearing would go forward as scheduled on paragraphs 13, 14, and 16 through 20 of Count I and paragraphs 21 through 24 of Count III of the Administrative Complaint.

On April 28, 1997, the Health Professionals Division filed a Superseding Administrative Complaint.

An administrative hearing was held in the matter before the administrative law judge who, on October 26, 1998, issued a Proposal for Decision setting forth recommended findings of fact and conclusions of law.

On November 4, 1998, Respondent filed a Motion for Reconsideration of Order Granting Partial Stay, requesting a stay of all administrative proceedings pending resolution of the related criminal matter.

On November 9, 1998, the Health Professionals Division filed the State's Response in Opposition to Respondent's Motion for Reconsideration of Order Granting Partial Stay.

On November 10, 1998, Respondent filed Respondent's Objections to Proposal for Decision.

On November 12, 1998, Respondent filed Respondent's Reply to State's Response in Opposition to Respondent's Motion for Reconsideration of Order Granting Partial Stay.

On November 24, 1998, the Health Professionals Division filed the State's Response to Respondent's Objections to Proposal for Decision.

On December 3, 1998, the administrative law judge issued an Order Denying Reconsideration of Partial Stay and Denying Oral Argument.

On January 19, 1999, Respondent filed a Petition for Remand & Stay with accompanying Brief in Support of Petition for Remand & Stay, requesting that the Board issue an order remanding the matter for hearings on the remaining allegations and staying the administrative proceedings pending final adjudication of the related criminal matter, and requesting oral arguments on the matter.

On January 19, 1999, the Health Professionals Division filed a letter in opposition to Respondent's Petition for Remand & Stay.

The Disciplinary Subcommittee, having reviewed the administrative record, considered the within matter at a regularly scheduled meeting held in Lansing, Michigan, on January 20, 1999, denied Respondent's petition for remand and stay of the administrative proceedings, and Respondent's request for oral arguments.

Further, the Disciplinary Subcommittee affirmed the administrative law judge's findings of fact and conclusions of law in the Proposal for Decision.

IT IS HEREBY ORDERED that for violations of sections 16221(a), 16221(b)(i), and 16221(b)(vi) of the Public Health Code, supra, Respondent's license to practice medicine in the state of Michigan is SUSPENDED for a minimum period of six months and one day, commencing on the effective date of this order. The periods of suspension shall run concurrently.

IT IS FURTHER ORDERED that reinstatement of a license which has been suspended for more than six months is not automatic and, in the event Respondent applies for reinstatement of his license, application for reinstatement shall be in accordance with 1996 MR 7, R 338.1635. Further, Respondent shall supply to the Michigan Board of Medicine, pursuant to section 16247 of the Public Health Code, supra, clear and convincing evidence that Respondent is of good moral character, is able to practice the profession with reasonable skill and safety, and that it is in the public interest for Respondent to resume the practice.

IT IS FURTHER ORDERED that for the aforesaid violations of the Public Health Code, Respondent is FINED in the amount of $5,000.00, to be paid to the State of Michigan prior to Respondent's application for reinstatement of his license. The fine shall be mailed to the Department of Consumer & Industry Services, Office of Health Services, Credentials Unit, P.O. Box 30185, Lansing, Michigan 48909. The fine shall be paid by

check or money order made payable to the State of Michigan, and the check or money order shall clearly display (or show) the formal complaint number 43-94-5210-00.

IT IS FURTHER ORDERED that in the event Respondent violates any provision of this order, and if such violation is deemed to constitute an independent violation of the Public Health Code or the rules promulgated thereunder, the Disciplinary Subcommittee may proceed to take disciplinary action pursuant to 1996 MR 7, R.338.1632 and section 16221(g) of the Public Health Code, supra.

IT IS FURTHER ORDERED that this Order shall be effective 30 days from the date signed by the Disciplinary Subcommittee's Chairperson or its authorized representative, as set forth below.

Dated: January 29, 1999

MICHIGAN BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

By _____
Carole Hakala Engle, Director
Health Licensing Division

This is the last and final page of a Final Order in the matter of Jose Gilberto Higuera, M.D., Complaint Number 43-94-5210-00, Docket Number 96-0616, before the Disciplinary Subcommittee of the Michigan Board of Medicine, consisting of five pages, this page included.

8H

STATE OF MICHIGAN

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

OFFICE OF LEGAL SERVICES

In the matter of

Office of Health Services
Petitioner

v

Jose Gilberto Hiquera, M.D.
Respondent

_____/

Docket No. 96-0616

Agency No. 43-94-5210-00

AgencyName: OHS

Case Type: Sanction

Issued and entered
this 26th day of October 1998
by Renee A. Ozburn
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

On July 22, 1996 an Administrative Complaint was issued in this matter. On January 7, 1997, oral argument was heard on the Respondent's Motion to Stay Proceedings. On January 10, 1997, this Administrative Law Judge(ALJ) issued an Order Granting Partial Stay of Allegations. Hearings began on April 22, 1997 and continued on April 23rd, 24th and 25th. On April 28. 1997, the Petitioner issued a Superceding Administrative Complaint. (Complaint) The final day of hearings was August 12, 1997. The record remained open until early April 1998.

Throughout these proceedings the Petitioner has been represented by Assistant Attorney General Merry Rosenberg.The Respondent, Dr. Jose Hiquera, did not appear at any of the hearings but was at all times represented by Attorney Max Hoffman.

ISSUES AND APPLICABLE LAW

Paragraphs #1 through #22 in the original and superceding Complaint(s) are the same. In this ALJ's Order dated January 10, 1997, paragraphs #7 through #12 of Count I, and paragraph # 15 of Count II, were Stayed. The Petitioner amended its Complaint at the beginning of the hearings on April 22, 1997. The amended paragraphs (i.e. #23 through #25) were also Stayed.

The hearings proceeded on allegations in paragraphs # 13, 14, 16, 17, 18, 19 and 20 of Count II and paragraphs #21 and 22 of Count III of the Complaint. These allegations assert that the Respondent altered a patient's chart and reused IV bags and syringes between patients in violation of the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 et seq; MSA 14.15(1101) et seq, (Code), Sections 16221(a), (b)(i) and (vi) which provide as follows:

Sec. 16221. The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:

(a) 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 the health profession.

(b) Personal disqualifications, consisting of 1 or more of the following:
(i) Incompetence.
(vi) Lack of good moral character.

EXHIBITS

Petitioner Exhibits:

#1 A copy of Ultrasound Findings dated 10/14/94, re: patient D.D.(initials used to protect privacy of patient)

#2 Patient chart re: D.D.

#3 Abortion price chart

#4 Laminaria Informed Consent form

#5 4 pages from D.D. patient chart

#6 An IV Bag (remanded to the care of Atty. Rosenberg)

#7 Photograph of an IV Bag

#8 Syringes (remanded to care of Atty. Rosenberg)

#9/9a ESDA film and photocopy of film

#10/10a ESDA film and photocopy of film re:Q-8

#11 Calculations of Erich Speckin

#12/12a ESDA film and photocopy of film re: Q-12

#13/13a ESDA film and photocopy re: Q-11

#14/14a ESDA film and photocopy re:Q-13

#15/15a ESDA film and photocopy re:Q-14

#16 Not Admitted

#17 Bottle of Diazepam (remanded to care of Atty. Rosenberg)

#18 Not Admitted

#19 Not Admitted

#20 Maude Guerin, M.D., Curriculum Vitae

#21 Sparrow Hospital policy re: IV Bags

#22 Not Admitted

#23 Excerpts from J.H. deposition(excepting lines 1-10 p. 65)

Respondent Exhibits:

A - Erick Speckin Paper re: Ink Dating

B - Not Offered

C- Not Offered

D - Butterfly Infusion Set (remanded to care of Atty. Hoffman)

E -Not Admitted

F -Not Admitted

SUMMARY OF EVIDENCE

Re: Allegation of Patient Record Alteration

Witness: D.D.

Patient D.D. testified, in a deposition taken June 11, 1997, that she called the Respondent's office in October 1994 to inquire about obtaining an abortion. She called a number that was listed in the Yellow Pages. She was asked some questions over the phone. She believes the person who answered the phone identified herself as "Sharon". D.D. told this person that she thought she was about 22 to 23 weeks pregnant and was given a price for an abortion procedure in the range of $1,900 for that length of a pregnancy. D.D. asked sone questions about whether insurance would pay for the procedure and was promised a return call with that information. A person called her back and told her that she would have

to bring $1,600 in cash and her insurance would pay the $300 balance.

D.D. was advised to come in soon because they wouldn't want her to be "further along". She acknowledged that she was not sure of exactly how long she had been pregnant because she still had some menstruation after she became pregnant. This had also happened when she was pregnant with her oldest child. She was informed that it would be a two day procedure.

On October 14, 1994 she arrived at the Respondent's Highland Park office and tendered the $1,600 cash she had been told to bring. She was told that an ultrasound would be performed and then a Laminaria. D.D. testified that a "nurse" named "Rebecca" came in and performed an ultrasound. After performing the procedure Rebecca said "Uh-oh" and when D.D. inquired about what she meant, Rebecca told her "I think you're a little further along than what you said." When D.D. expressed concern, Rebecca said "...we'll let the doctor see what he says when he comes in."

When the Respondent came in, he looked at "it" and said to Rebecca something like "I think you're right". She is sure he was referring to the ultrasound because he was looking directly at the ultrasound picture when he said " it". The Respondent then asked D.D. why she wanted an abortion and she told him " because it's not the right time". He asked a few other questions about whether she had a job and where she lived and then told her an abortion would cost $3,000. When she asked him why the price had increased he said it was because she was a couple of weeks farther along than what she had been originally priced for. He also told her once he began the Laminaria procedure she would not be able to change her mind.

D.D. testified that the Respondent told her after he inserted the Laminaria sticks on the first day

of the procedure she might have some cramping and she might go into labor and, if that happened, she was to call Rebecca rather than go to a hospital. When she asked what he meant about her going into labor, he told her she might deliver a "live baby". Although D.D. remembers being told that she was "27 and a half" weeks pregnant, she can not remember if only Rebecca made that statement or whether the Respondent also stated the actual length of her pregnancy. D.D. paid a total of $1,900 herself and her insurance paid another $1,100 for the procedure(s).

D.D. had not seen any other physician/ OB-GYN regarding her pregnancy before going to the Respondent for an abortion. She acknowledges that she filled out a patient history form at the Respondent's office indicating that her last menstrual period started April 25, 1994. That was her best estimate at the time she filled out the form. If this had been accurate she would have been about 22 or 23 weeks pregnant by October 14,1994. However, because she had continued to have menstrual flow well into her previous pregnancies she never asserted that she was absolutely sure of how far along she was in her pregnancy based on a menstrual date.

At no time was there any discussion about the "legality" of an abortion depending on the weeks of pregnancy. D.D.'s main concern was whether the procedure would be detrimental to her health. She gave the Respondent permission to proceed with the abortion. D.D. never filed a complaint with anyone concerning the abortion and was only brought into this matter after being contacted by the state. It was not her desire to end up discussing this very personal matter with anybody.

Witness: Randi Holtzman

Randi Holtzman is a Health Professional Investigator with the Department of Consumer and

Industry Services (CIS). In January 1995 she began an investigation of the Respondent after Rebecca Black filed a complaint with the state alleging that he performed illegal late term abortions and reused IV bags and syringes. Ms. Black never made any allegation that the Respondent had altered patient records. Ms. Holtzman interviewed Ms. Black at Ms. Black's home on January 24, 1995. Ms. Black gave Ms. Holtzman documents, including patient records, as well as syringes, IV bags and bottles of medication. Exhibits 1 and 4 are documents given to Ms. Holtzman on January 24, 1995. She does not know if they are copies or originals. Ms. Holtzman inventoried the items and copied documents and returned them to Ms. Black. Ms. Holtzman subpoenaed D.D.'s original patient records on April 1, 1995 and she received them (Exhibit 2) on May 24, 1995, from the Respondent's attorney.The Exhibit 2 records were stored in Ms. Holtzman's working file in her Detroit office and then transferred to her supervisor's possession.

When Ms. Holtzman received the Exhibit 2 records in May 1995, she compared them with the documents given to her by Ms. Black in January 1995. She noticed a decrepancy between the Exhibit 1 ultrasound form provided by Ms. Black indicating "28 weeks" for D.D. on 10/14/94 and the ultrasound form in Exhibit 2 indicating "24 weeks" for D.D. on 10/14/94.

Witness: Rebecca Black

Rebecca Black was hired by the Respondent as a medical supervisor in September 1986. She remained in this position until November of 1994. Ms. Black is not licensed as a health professional. She has had some training in a "nursing assistance program" and she completed approximately 10 months of training towards obtaining her LPN certification. She has worked for physicians in Michigan since

approximately 1977. For over six years she worked as a medical supervisor at the Woman's Counseling Center. Her duties at the Center included performing ultrasounds on pregnant women to determine the status of a fetus as well as for treatment of fibroids.

When Ms. Black worked for the Respondent, he had an office in Highland Park and one in Bloomfield Hills, Michigan. Ms. Black worked at both offices. The Respondent performed pap tests, ultrasounds and abortions in the two offices. Ms. Black's responsibilities in the office increased over time from ordering supplies to having more direct patient contact. She assisted the Respondent in performing ultrasounds and abortions.

Ms Black described in detail her understanding of the procedure for performing an ultrasound. When the test was to determine gestational age she described her process as follows:

> "...first you make sure the table's clean... put the patient on the table and drape her. Put the cream on whatever area (of) her stomach at an area where you're going to do it. And make sure the machine is on. And we use the sound. You move it backwards and forward (indicating) and tape what you're looking for... (for gestational age). You have to know what you are looking for. Gestational age is just a sac. It's a sac of pregnancy."

Ms. Black described a bi-parietal measure (i.e., BPD) as the "head measure". A caliper is used to measure the head, or fetal skull. Where the calipers are placed depends on how the head is featured on the ultrasound screen. The calipers can be placed on the inner or outer skull to get a measurement, again depending on how the head is featured on the screen. Different doctors prefer one or the other (i.e. inner or outer) but the Respondent never instructed Ms. Black regarding a preference. However, once the calipers are placed, a "BPD" button on the ultrasound machine is pushed and it gives out a gestational age reading (e.g. "23 weeks").

According to Ms. Black, the Respondent did not do pelvic exams to determine gestational age. The normal practice was that after Ms. Black performed an ultrasound, the Respondent accepted her findings unless she asked him to recheck or redo the test. Only the ultrasound report was used for determining actual gestational age. The Respondent's staff used a "wheel" that would calculate weeks of pregnancy, based on what a patient reported as her LMP, only to give an estimated cost for an abortion procedure.

The ultrasound machine used in the Highland Park office produced a Polaroid picture and the machine in Bloomfield Hills produced a printout. To calibrate the length of a pregnancy generally a "crown to rump" measurement was taken for earlier pregnancies and a "BPD" measurement was taken in later pregnancies. In pregnancies that were further along, Ms. Black might ask the Respondent to repeat the ultrasound himself. A two day procedure was also used with pregnancies that were deemed to be over 15 weeks. The Respondent always made the final determination of the age of a fetus.

On October 14, 1994, patient D.D. came to the Highland Park office and Ms. Black performed an ultrasound on her. According to Ms. Black's testimony, and the Exhibit 1 patient record filled out with Ms. Black's and "Mary's" handwriting, the ultrasound indicated that patient D.D. was 28 weeks pregnant based on the measurements she took. Ms. Black acknowledged that only the Respondent is qualified to actually "establish" gestation. Although a picture was produced with the ultrasound used in Highland Park, it was not placed in the patient file pursuant to office policy. Ms. Black showed the Respondent the picture and reported her findings indicating a 28

week fetus. The Respondent told Ms. Black he would check the patient and make a decision on whether " he would do her or not"

Ms. Black asserts that, in her presence, the Respondent did his own ultrasound on patient D.D. and the machine read "28 weeks" a second time. He told D.D. that this was a little beyond when he would normally do an abortion, but if she promised not to go to a hospital after he started the abortion process he could do it. According to Ms. Black, this was because if she went to a hospital they would probably deliver a live fetus that could get the Respondent in trouble. He gave D.D. Ms. Black's home phone number in case she went into labor during the night between the two day procedure so that they could then meet at the clinic instead of the hospital.

Ms. Black testified that the Respondent never did an ultrasound on D.D., in her presence, showing the patient to be 24 (vs. 28) weeks pregnant. The Exhibit 1 Ultrasound Form does not contain a signature in the place for the "Sonographer". Ms. Black stated that she never signed these forms, the Respondent normally did.

Ms. Black testified that normally the Respondent filled out patient charts and billing forms. in her presence, at the desk, after leaving an examination room or before he left the office for the day. However, he did not complete D.D.'s ultrasound form in her presence. She identified the writing on the Exhibit 2 ultrasound form indicating "24 weeks" as the Respondent's.

According to Ms. Black, she was involved in putting patient records together and she testified to the usual order in which documents were placed in a file and what might be stapled together. The usual order was; 1) patient history sheet, 2) consent for termination, 3)arbitration

agreement, 4)ultrasound sheet, 5)anesthesia explanation, 6) laboratory sheet and 7) a physical exam sheet. All of these would be stapled together. Putting these charts together in the above order did not always occur on the day of the patients visit, but rather when staff had time.

Ms. Black acknowledges that she took patient D.D.'s file home without permission when she decided to file a complaint against the Respondent. When she called the Wayne County Medical Society with her concerns they informed her she would need proof for any accusations . Therefore, when she removed files from the office she did not consider it to be stealing especially since she returned them. She made copies of patient D.D.'s medical records and put the originals back in the charts which she returned to the office files. After she gave the files to Investigator Holtzman , and they were returned to her, she kept them in her bedroom until they were given to Attorney Rosenberg.

Ms. Black also acknowledged an acrimonious relationship with the Respondent by the time her employment ended. Some of the complaints that she expressed to Investigator Holtzman were that she thought the Respondent was a racist who discriminated between black and white patients and that he talked to her like she was a child. She admits that in one angry confrontation she threw a chair, but she asserts that this was to let off steam rather than to harm the Respondent. She contends that many of the physical and emotional problems she is still dealing with began with the stresses of her employment with the Respondent.

Witness: Sharon Biskner

Sharon Biskner was certified as an Administrative Medical Assistant in 1981. She began

working at the Respondent's Bloomfield Hills office in 1986. Her job included receptionist, clerical, bookkeeping, filing and some patient care duties. She worked with the Respondent until November 1995. She worked with Rebecca Black over an 8 year period when they were both employed with the Respondent.

Ms. Biskner identified the Exhibit 2 Ultrasound form. She stated that everything except the signatures is in her handwriting. This form indicates that D.D. had an ultrasound on 10/14/94 for "Gestational Age" and the ultrasound findings were that the age was "24 weeks". She identified the signature for "Sonographer" as the Respondent's. Ms. Biskner testified that she did not see D.D. on 10/14/94 because she was only working in the Bloomfield Hills office at that time, and D.D. was seen in the Highland Park office. On the day Ms. Biskner filed out this form she had been asked for an ultrasound form by the Respondent. She then wrote the patient information that the Respondent dictated to her on the form. She did not see D.D.'s complete patient chart at the time she filed out the form and she never saw another ultrasound form indicating a "28 week" gestational age for D.D. on 10/14/94. Although Ms. Biskner indicated that the Respondent would sometimes ask her for a duplicate sheet for a chart if an error had occurred, no notation was made in the charts indicating a replacement form was being added to a chart. When Ms. Biskner filled out the form regarding patient D.D., it was the only time she was ever asked to assist with an ultrasound form. She confirms that there is no place on the form indicating the date that it is signed by the Respondent, as opposed to the date of the procedure.

Ms. Biskner stated that part of her responsibilities was maintaining patient records and so she was familiar with the different forms in D. D.'s charts. One of the first pages of her chart is a November 16,

1994 request by D.D.'s insurance company for an "operative report" from Respondent's office. Ms. Biskner, or other staff who dealt with maintaining records, would send this information back to the insurance company after obtaining all of the necessary information from documents in the records. Exhibit 2 contains a fee agreement signed by D.D. in which the "total facility fee" to be billed to her insurance company is "$1,600".

Ms. Biskner identified the Exhibit 3 abortion fee chart used in Respondent's office. The fee of $1,600 is indicated as the price for a 22 week abortion. However, in further testimony based on the Exhibit 2 records, Ms. Biskner agreed that the total cost of D.D.'s abortion was $3,000, which corresponds on Exhibit 3 to 26 weeks.

Witness: Mary Roettger

Mary Roettger has worked at both of the Respondent's offices since February 1994. At the time of her testimony in August 1997 she was still employed there. She is a receptionist. Her duties include answering the phone, making appointments and helping patients fill out forms. She testified that what a patient reports as her LMP is used to determine fee estimates. However, patients are informed that the ultrasound results will be the ultimate determiner of fees, and that the Respondent makes that determination. Although the Exhibit 3 fee schedule was in place when she started, the price list changes from time to time according to decisions made by the Respondent. At the time of her testimony, the price list did not go past 24 weeks.

Ms. Roettger testified that she has never processed a patient for a 25, or more, week abortion. She has informed patients who indicate they believe they are 24 + weeks pregnant that if this is true, or the

Respondent determines them to be more than 24 weeks along, no abortion will take place. She has seen ultrasounds indicating a patient was 24+ weeks pregnant and she has talked to rejected patients and made referrals.

Witness: Maude Guerin, M.D.

Maude Guerin M.D. is a Board Certified OB/GYN, licensed in Michigan since 1984. Her Curriculum Vitae was entered as Exhibit 20. She is part of a group practice entitled "Mid-Michigan Women's Health Care" with 4 other OB/GYN's, in Lansing. She has performed abortions in a private clinic setting. Dr. Guerin was qualified to give expert testimony. She reviewed the Respondent's patient records for D.D. and the testimony of Rebecca Black.

Dr. Guerin testified that gestational age can be measured by a variety of methods, all based on the fact that a fetus grows at a fairly constant rate up to about 20 to 22 weeks gestation. For example, a baby that is destined to be 10 pounds at birth will measure the same at 10 weeks gestation as a baby destined to be 5 pounds at term. Therefore, by measuring a large number of babies at various ages it is possible to correlate size with gestational age.

In a pregnancy thought to be no more than 10 to 11 weeks the more common measurement is the "crown/rump" method which basically measures the length of the fetus. As the fetus develops, other parts can be measured, most commonly, the head. The head measurement used most often is the BPD, although the circumference can also be used. The BPD is usually determined using a calibrated machine. The standard way of obtaining a BPD is to measure at the level of the thalamus which is an intra cranial structure that can be seen on the ultrasound. The process that Ms. Black described regarding how calipers

are placed on the inside and outside of the skull was confirmed as the correct process by Dr. Guerin.

Dr. Guerin stated that a person does not need to be a physician or understand the physics of the ultrasound machine to be able to perform an ultrasound that accurately indicates gestational age. In Dr. Guerin's experience ultrasound machines are calibrated and serviced by registered technicians. The machines are programed to take the distance between the calipers and translate that into weeks.

According to Dr. Guerin the ultrasound is the most accurate tool available for measuring gestational age. A pelvic exam is less accurate for various reasons, especially after 15 to 16 weeks gestation. The ultrasound is also more accurate than using the LMP to determine gestation because a woman can have bleeding that she perceives to be a period after becoming pregnant.

Finally, Dr. Guerin spoke to the issue of how to make changes or corrections to a patient's chart. She stated that the standard of care requires that if there are late entries (i.e. not contemporaneous with treatment) they should be identified as late entries or corrections and should be dated and contain the signature of the person making the changes. Since nurses or assistants doing preliminary exams chart their findings, if a physician disagrees with those findings, the physician should make a notation of his or her separate findings. The physician should not erase or take the nurse or assistant's findings out of the chart, rather, the physician adds findings with an explanation of the differences. In Dr. Guerin's opinion the standard of care in the practice of medicine is compromised by removing records from a patient chart. If the Respondent did not create an ultrasound report contemporaneously with performing the procedure, the correct process would be to prepare one and indicate that it is a late entry which was not made contemporaneously with the patient's care.

Witness: Erich Speckin

Erich Speckin is a Forensic Document Analyst and Forensic Chemist qualified as an expert witness in the area of "ink dating". Subsequent to the close of the record in this matter, the Respondent filed a Motion to Reopen Proofs to address the issue of the reliability of ink dating based on information received after the hearings concluded.

This Administrative Law Judge finds it unnecessary to reopen the proofs. After reviewing the testimony and exhibits offered regarding the issue of ink dating, as it relates to crucial documents in this matter, I find that the conclusions reached by Mr. Speckin using this process are of little weight compared to the testimony of the other witnesses regarding essential facts. This is not a matter where scientific evidence, in the nature of document analysis, is determinative.

The majority of the analysis provided by Mr. Speckin dealt with whether impressions on documents that may have been above or under other documents , and the relative date of the ink on those documents, could establish that some documents were created at a time significantly different than a date appearing on the document. However, the issue of whether patient D.D.'s total chart was altered. is not dependent on whether a document was created at a date later than the date on that document. The issue is whether documents were created or replaced in the charts in a manner that alters crucial medical information about a patient. such that it is misleading or falsely represents the patients actual medical or physical condition. The competent, material and substantial evidence regarding this issue was presented by the patient, staff and the physician qualified to give expert testimony. The evidence offered

through Mr. Speckin is not material to the ultimate issue as expressed above.

Re: Allegation that IV's and Syringes were Reused

Witness: Respondent

Exhibit 23 contains excerpts from deposition testimony by the Respondent, taken in another matter, on October 17, 1995. The Respondent testified that he did use the same IV bag with the same intravenous solution in more than one patient after changing the intravenous set. He also acknowledged using the same syringe and needle to draw a drug (e.g. Demerol) from its' bottle and inject it into IV tubing on different patients. According to the Respondent, " the needle of the syringe does not touch the patient and does not get contaminated in the process, rather, it just remains as a (Demerol) drawing syringe."(Exhibit 23 pp. 129-130) In contrast, all syringes used to inject a patient directly were immediately disposed of.

The Respondent explained that the syringe used only to draw a drug out of a bottle, would be injected into a specific rubber section of the IV set which is at least 36 inches from the needle that is in the patient's vein. He believes it is highly unlikely for the patients blood to back up into this section of the IV tubing because of gravity, unless the IV bag was lowered to the floor. However, he acknowledged that there is no clamp or other apparatus that could physically stop blood from backing up in the tubing to the site where the drug is injected, other than gravity.

The Respondent also acknowledges using the same IV bags on different patients after changing the "IV set". For example, when he would use Pitocin with glucose, which is a potent drug , there is no

set dosage because every patient reacts differently. His procedure is to inject small doses and watch the patients reaction. If the total amount of Pitocin in an IV bag was not used on a given patient, he might use the remaining Pitocin, in that bag, on another patient after changing the IV set.

Witness: Rebecca Black

Ms. Black testified that although the Respondent used one IV bag per patient when she began working for him, this changed about 1 to 2 years before she left. According to Ms. Black, the Respondent told staff there was nothing wrong with this as long as the "butterfly needle at the end" was changed. She described the butterfly needle as the needle that goes into the patient from the IV bag. Some IV bags were kept hanging overnight for use with the next day's patients. Ms. Black asserts that she questioned the propriety of this because in her LPN training they were taught that only one IV bag per patient was appropriate to prevent possible contamination from blood backing up in the IV tube.

Ms. Black also stated that around the same time the Respondent changed his policy on use of IV bags he also ordered a change in how syringes were used. He told Ms. Black to label syringes each day with the medications they were using (e.g. Valium, Demerol or Versed) and that same syringe would be used to draw the medicine indicated on its label until the bottle of medicine was used up. If the bottle of a particular medicine was not used up with one patient, the same syringe would be used to draw medicine for other patients. According to Ms. Black, the Respondent instituted this policy because he said they were using too many syringes. The Exhibit 8 syringes included labels that Ms. Black identified as her handwriting. Ms. Black indicated that she would prepare 5 syringes each day for the Highland Park office and then in the afternoon when they switched to Bloomfield Hills, five more syringes would be prepared

for that office.

When Ms. Black questioned the Respondent about the propriety of using the same syringe with different patients, he said it was safe as long as they didn't get any blood in them or put any needles into the patients arms (i.e., as opposed to using the syringe to inject the IV bag). Her concern was about the possibility of contamination because when an IV tube is squeezed sometimes blood from the patient shoots up the tube and could come in contact with the syringe being used to inject medication into the IV bag. That blood could then be transferred to the next patient if the same syringe is used. If Ms. Black actually saw blood on a syringe she threw it away, but other staff were also responsible for filling syringes and using IV bags and she can't attest to their practices. Further, there is always the possibility that blood could be present that was not visible.

Witness: Sharon Biskner

Sharon Biskner also testified that IV bags were moved from room to room and used on more than one patient. Although she changed the tubing and infusion set on an IV bag occasionally, this was not one of her regular duties. Ms. Biskner did discuss the cost of IV sets with the Respondent and he expressed a concern about keeping over head cost down. She was unaware of whether syringes were used on multiple patients.

Witness: Richardean Jackson

Richardean Jackson began working with the Respondent as a medical office assistant in 1991. Her duties include taking patient blood pressure and temperature readings and preparing them for ultrasounds. Each day she also prepares medications and makes sure new IV bags and IV butterflies sets are available

in each room. Ms. Jackson testified that (as of the time of her testimony in August 1997) the current procedure in the office was to use only one IV bag and butterfly set per patient. This is also the current procedure for using syringes. After a syringe is used to inject medicine into an IV bag or directly into a patient, it is disposed of in a SHARP container. The policy of using only one IV and one syringe per patient has been in effect since late 1994.

Witness: Maude Guerin, M.D.

Dr. Guerin testified that the minimum standard of care for use of intravenous infusion sets, including the IV bags and IV tubing is that they are for single patient use only. This was identified as standard procedure in hospitals as well as in clinic settings. Further, this would have been the standard of care applicable in 1994 and earlier. The standard of care for using syringes is also single patient use only. This standard is applicable even if the treatment is considered minor surgery. The issues of integrity and sterility of the IV's and syringes exist under all situations of sharing IV's and syringes between patients.

The rationale for single patient use of IV's and syringes is that when a needle (i.e. of a syringe) is introduced through a diaphragm such as the rubber diaphragm at the end of IV tubing, it then becomes part or contiguous with the patient's system. When the needle is in the IV tubing and is then taken out of the IV tubing and put into another patient's IV tubing, essentially, the second patient is being exposed to the first patient's bloodstream. This has the potential of exposing the second patient to lethal infections acquired from a previous patient.

When , as is the case with IV's and syringes, certain risks can be totally eliminated by following

basic and easy procedures, there is no difference between a "minimal standard of care" and a basic "standard of care". Dr. Guerin opined that reusing IV's and syringes constitutes a breach of the physician's duty to patients that is beyond a failure to follow minimum or basic standards of care, rather it becomes an act of negligence. It does not diminish the negligence if a syringe is used only to transfer medicine from a single, multidose bottle to an IV infusion set used by more than one patient. It also does not negate the negligence that the same syringe needle was only used to transfer medicine from a bottle to IV tubing, but not directly into a patient. In Dr.Guerin's opinion there is never a justifiable reason to transfer IV bags and tubing or to reuse syringes for treatment of more than one patient. Blood and infectious agents are microscopic, and it can take small amounts of these agents to cause infection. Further, bacteria can grow in IV tubing if the bags are left overnight after use on a patient which can be transferred to another patient.

Character Witnesses

The Respondent presented the deposition testimony of the following witnesses who were not called as experts and had no personal involvement in the facts alleged in the complaint in this matter:

1. Jose Siero, M.D.

2. Donald Bradley, M.D.

3. Joseph Berke, M.D.

4. Alberto Hodari, M.D.

5. Angel Ojeda, M.D.

6. Rodolfo Finkelstein. M.D.

7. Enrique Gerbi, M.D.

8. Linda Federhart

9. Carmen Franco

Among the opinions, descriptions and accolades given by the above character witnesses , the Respondent was found to be a caring, compassionate and competent surgeon. The witnesses were generally familiar with the charges against the Respondent. The physicians who gave opinion testimony generally agreed that removing an original patient chart and replacing it without indicating that a new or corrected/updated chart was being placed in a file would be wrong. They also generally agree that the standard of care for use of IV's and syringes is "one per patient". Some of the witnesses did not believe that the Respondent could have committed acts that would correspond with less than competent care. The physicians who had worked with or had used the Respondent as a substitute in their practices, were generally in agreement that the Respondent was competent and they did not question working with him in the future.

FINDINGS OF FACT

Re: Altering Patient Records

The testimony of patient D.D., Rebecca Black, Randi Holtzman and Dr. Maude Guerin most credibly established the following facts:

1) The Respondent was aware that an ultrasound done by Ms. Black on patient D.D. October 14, 1994. in his Highland Park office, showed 28 weeks.

2) The Respondent did a second ultrasound on October 14, 1994 that showed that D.D.

was more than 24 weeks pregnant.

3) Both Ms. Black and the Respondent told D.D. that she was more than 24 weeks pregnant.

4) Ms. Black prepared an ultrasound form indicating her findings of 28 weeks gestation.

5) The Respondent did not sign the ultrasound form prepared by Ms. Black and did not prepare an ultrasound form contemporaneously with the ultrasound he performed on D.D. on October 14, 1994.

6) At some point, but not on October 14, 1994, the Respondent had staff person Sharon Biskner prepare an ultrasound form, in his Bloomfield Hills office, indicating that on October 14, 1994, he performed an ultrasound on patient D.D. which resulted in a reading of "24 weeks" gestation.

7) The Respondent did not make any notation anywhere in D.D.'s total medical records indicating that the form showing 24 weeks was not made contemporaneously with the performance of the ultrasound or that there had been readings by both he and Ms. Black showing that D.D. was as much as three or four weeks past 24 weeks.

8) Dr. Guerin, the expert witness for the Petitioner, established that a person does not have to be a physician to perform an accurate ultrasound. Rebecca Black's description of her experience and understanding of how to perform and read ultrasound results, is consistent with the testimony of Dr. Guerin's regarding the basic procedure for taking measurements that are put into the ultrasound machine.

9) Ms. Black was unaware that the Respondent had signed another ultrasound form indicating 24 weeks of gestation for patient D.D. on October 24, 1994.

10) The fact that Ms. Black left her employment with the Respondent under less than amiable conditions, does not negate the credibility of her testimony concerning patient D.D.'s ultrasound on October 14, 1994

11) At the time Ms. Black showed state investigator Holtzman patient D.D.'s medical records and file in January 1995, there was no ultrasound form in the records showing a 24 week pregnancy on October 14, 1994.

12) The Respondent did not produce the 24 week ultrasound form contemporaneously with the procedure, rather he created the 24 week form more than three months after the procedure.

13) Patient D.D. and her insurance company paid the Respondent approximately $3,000 for the procedure which, according to the Respondent's fee schedule in place in October 1994, would have corresponded to procedures for patients over 24 weeks pregnant.

14) The Respondent knowingly misrepresented the actual medical condition of patient D.D. by placing the 24 week ultrasound form in her file.

15) The Respondent failed to accurately and ethically make changes to a patient's file in accordance with minimal standards for adding or deleting crucial patient information.

Re: Reusing IV's and Syringes

The testimony of the Respondent, Rebecca Black, Sharon Biskner and Dr. Maude Guerin most credibly established the following facts:

1) The Respondent acknowledged that for a period of time, it was a standard procedure in his offices to reuse IV bags and the syringe/needles used to draw medicine from a particular bottle for infusion into the tubing of an IV bag.

2) The Respondent did not believe he was putting patients at risk by having them share IV bags or by reusing needles to infuse medicine into IV sets that were transferred between patients. The Respondent did not reuse syringe/needles for direct injection into a patient's skin.

3) Reusing IV's and syringes jeopardizes the integrity and sterility of the individual IV's and syringes and puts patients at risk of infectious agents from other patients.

4) When the risk of infection to patients from IV sets and syringes can be reduced to almost zero by using only one IV or one syringe per patient, to do otherwise for the sake of lowering cost, or for any other non-medical reason, is below the minimal standards of care prescribed for all doctors, in all locales and in all facilities providing medical care.

5) As of late 1994, the Respondent had instituted a one IV and one syringe per patient policy in his offices.

CONCLUSIONS OF LAW

The principles that govern judicial proceedings also apply to administrative hearings. The burden

of proof is upon the Petitioner to prove, by a preponderance of the evidence, that the Respondent violated the Code as alleged and that grounds exist for the imposition of sanctions. Smith v. Lansing School District, 428 Mich 248; 406 NW2d 825 (1987).

Section 16221(a)

Competent, material and substantial evidence was presented, to prove by a preponderance, that the Respondent altered a patient chart and/or medical record, in a manner that misrepresented the actual medical status of a patient who underwent treatment. Further, a preponderance of the evidence established that the Respondent reused IV's and syringes between patients. The Respondent's conduct constitutes a violation of his general duty and is conduct that impairs the safe and skillful practice of medicine. Therefore, the Respondent has violated Section 16221(a).

Section 16221(b)(i)

A preponderance of the evidence established that it is below the minimal standards of practice for a physician to alter a patient's medical records without proper notation of what has occurred. Further, it is, and has always been, below the minimal standards of practice for a physician to reuse IV bags and syringes between patients. The Respondent's conduct of altering a patient's records and reusing IV's and syringes constitutes incompetence. Therefore, the Respondent has violated Section 16221(b)(i)

Section 16221(b)(vi)

A preponderance of the evidence established that the Respondent knowingly put a misleading ultrasound form in a patients chart months after the procedure was performed. This conduct indicates a lack of propensity to serve the public in a fair, honest and open manner and demonstrates a lack of good

moral character. Therefore, the Respondent has violated Section 16221(b)(vi).

EXCEPTIONS

The parties may file Exceptions to this Proposal for Decision within fifteen (15) days after it is issued and entered. An opposing party may file a response within five (5) days after Exceptions are filed. Any such Exceptions shall be filed with the undersigned Administrative Law Judge at the Department of Consumer and Industry Services, Office of Legal Services, Ottawa State Office Building, 611 West Ottawa, Second Floor, Lansing, Michigan.

Renée A. Ozburn

RENEE A. OZBURN
ADMINISTRATIVE LAW JUDGE

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by facsimile and/or by mailing same to them at their respective addresses as disclosed by the file, with postage fully prepaid on the 26th day of October 1998.

Maraloy D. Thomas
Office of Legal Services

Max R. Hoffman, Jr.
Farhat & Story, P.C.
Suite 3, Beacon Place
4572 South Hagadorn Road
East Lansing, Michigan 48823-5385

a copy was sent ID mail to:

Merry A. Rosenberg
Assistant Attorney General
Department of Attorney General
Health Professionals Division

Ray R. Garza, Manager
Complaint Section
Office of Health Services

STATE OF MICHIGAN

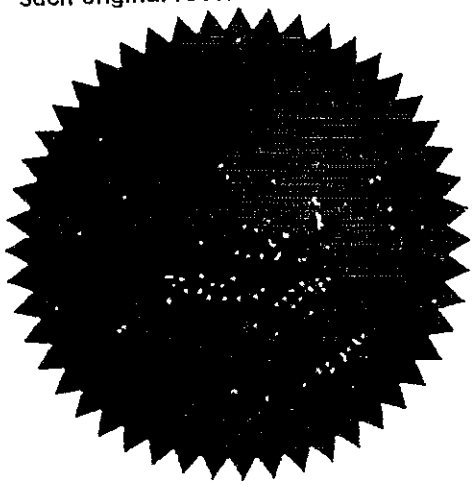
DOCUMENT CERTIFICATION

STATE OF MICHIGAN,
COUNTY OF WAYNE,
CITY OF DETROIT } ss.

I, CATHY M. GARRETT, Clerk of the Third Judicial Circuit Court do hereby certify that the foregoing is currently taken and copied from the original record in the case of

People vs. JOSE G. HIGUERA Case No. 97008841

now remaining in my office, and of record in said Court, and that the sane has been examined and compared by me with the original of said record in said cause, and that it is a correct transcript therefrom, and of the whole of such original record.



In Testimony Whereof, I have hereunto set my hand and affixed the seal of said Court, this 12TH day of JUNE in the year two thousand and ONE.

CATHY M. GARRETT – Clerk

Per Christina Phillips
Deputy Clerk

CHRISTINA PHILLIPS

ATTACHMENT 2

STATE OF MICHIGAN THIRD JUDICIAL COURT CRIMINAL DIVISION	PRETRIAL SETTLEMENT OFFER AND NOTICE OF ACCEPTANCE	CASE NO. 97-008841 PROS. WAR. NO.

THE PEOPLE OF THE STATE OF MICHIGAN v. Defendant's Name: JOSE G. HIGUERA

SID | LPD

PRETRIAL SETTLEMENT OFFER

☒ No charge reduction ☐ Charge reduction

	COUNT: SPECIFY CHARGE(S)	PACC	ATTEMPT 750.92	STATUTORY MAXIMUM PENALTY
1	ALTERED MEDICAL RECORD	750.492A1A		4

☐ Sentence Agreement ☐ Agree to Guideline Sentence ☐ Sentence Recommendation

* COBBS

DISMISS COUNT II

☐ People agree to PA 511 sentence ☐ People object to PA 511 sentence

☐ Sentence is mandatorily consecutive by law to _____

☐ People agree to withdraw notice to enhance sentence.

☐ Dismiss COUNT II in exchange for plea in this case.

☐ Other prosecutorial agreement _____

5/7/01 Date

~~Prosecuting~~ Attorney GENERAL

NOTICE OF ACCEPTANCE

I HEREBY ACCEPT THE ABOVE PRETRIAL SETTLEMENT OFFER AND WAIVE THE FOLLOWING RIGHTS:

1. THE RIGHT TO A JURY TRIAL OR TRIAL BY THE COURT WITH THE PROSECUTOR'S CONSENT.
2. THE RIGHT TO BE PRESUMED INNOCENT UNLESS PROVEN GUILTY BEYOND A REASONABLE DOUBT.
3. THE RIGHT TO CONFRONT AND QUESTION THE WITNESSES AGAINST ME.
4. THE RIGHT TO HAVE THE COURT COMPEL WITNESSES TO COME TO COURT AND TESTIFY FOR ME.
5. THE RIGHT TO TESTIFY AT MY TRIAL. THE RIGHT TO REMAIN SILENT AND NOT HAVE MY SILENCE USED AGAINST ME.
6. THE RIGHT TO CLAIM MY PLEA WAS THE RESULT OF PROMISES OR THREATS NOT DISCLOSED TO THE COURT, OR THAT IT WAS NOT MY CHOICE TO PLEAD GUILTY.
7. THE RIGHT TO APPEAL AS OF RIGHT AS TO CONVICTION AND SENTENCE.

J. G. Higuera — Defendant

5-7-01 — Date

Defense Attorney

5/7/01 — Date

Form #71 (5/98)

Distribution: White—Court File Yellow—Prosecutor Pink—Defense Attorney

Form CRIMCVS 8CRCVSENT1 CLKGRAHAM FA

STATE OF MICHIGAN COUNTY OF WAYNE THIRD JUDICIAL CIRCUIT COURT	ORDER OF CONVICTION AND SENTENCE	CASE NO. 97008841-01

THE PEOPLE OF THE STATE OF MICHIGAN vs. HIGUERA,JOSE,GILBERTO
Defendant

1. At a session of the court on 5/07/2001 before the Hon. BOYKIN,ULYSSES W

a Judge of the court, the defendant was convicted by: ☐ Jury ☐ Court ☒ Plea

of the offenses(s) PACC code(s)

750492A1A MED-FLS INFRMN

2. The defendant was in court for sentence on 5/30/2001 and was sentenced by the court to:

☒ Probation, for a term of 1 years. (see separate probation order)

☐ Michigan Department of Corrections, confined for a term of not less than nor more than _____ years.

The maximum statutory penalty for the crime(s) of which said defendant stands convicted is _____ years.

☐ Jail confinement for _____ days/months.

☐ The conviction is reportable to the Secretary of State under MCL257.732 or 281.1040.

The defendant's drivers license number is _____

RECOMMENDATION _____

☐ HIV testing was ordered on _____

The defendant was represented by ATTORNEY Max Hoffman BAR NO 23199

and is to be given credit for _____ days served in JAIL.

SAID CREDIT TO BE APPLIED TO MINIMUM AND MAXIMUM SENTENCE.

Ulysses W. Boykin
Judge