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

In the Matter of

Reginald D. Sharpe, D.O.
License No. 51-01-010839 Complaint No. 51-22-000436
_________________________________/

ADMINISTRATIVE COMPLAINT

Assistant Attorney General Bridget K. Smith, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Reginald D. Sharpe, D.O. (Respondent), alleging upon information and belief as follows:

1. The Board of Osteopathic Medicine & Surgery, an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.*, is authorized to find that a licensee has violated the Code and impose sanctions through its Disciplinary Subcommittee under the Code.

2. Respondent is currently licensed to practice osteopathic medicine and surgery pursuant to the Code. At all relevant times, Respondent practiced as an independent contractor at Summit Medical Center in Detroit, Michigan.

3. Section 16221(a) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or not injury results, or any conduct,

practice, or condition that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession.

4. Section 16221(b)(i) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for personal disqualifications, consisting of incompetence, which is defined in section 16106(1) of the Code to mean a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs.

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

PRIOR DISCIPLINARY ACTIONS

6. On July 28, 1998, the Bureau issued an administrative complaint alleging Respondent improperly delegated the administration of schedule IV-controlled substances. On December 9, 1998, the Board's Disciplinary Subcommittee accepted a consent order and stipulation resolving the matter and placing Respondent on probation to complete specified continuing education courses and payment of a $2500 fine.

7. On March 31, 2005, the Bureau issued an administrative complaint and order of summary suspension based on allegations that after beginning an abortion procedure, Respondent left the facility, and the patient subsequently began bleeding profusely and ultimately delivered a stillborn baby at the facility with only

the assistance of her mother. Respondent did not return to the facility to assist the patient and she was ultimately transported to the hospital for further care. On June 9, 2005, the Board's Disciplinary Subcommittee accepted a consent order and stipulation resolving this matter which dissolved the summary suspension and suspended Respondent's osteopathic license for 120 days. Upon reinstatement, Respondent was placed on probation for one year during which he was required to submit quarterly reports from a Board member assigned to review his practice. Respondent was also fined $5000 dollars.

8. On October 28, 2016, the Bureau issued an administrative complaint that based on allegations that Respondent performed several abortion procedures that resulted in perforation of the patients' uteri and that Respondent's documentation for those patients was substandard. On October 5, 2017, the Board's Disciplinary Subcommittee accepted a consent order and stipulation that placed Respondent on probation to undergo a review of his records by a member of the Board and completion of specified continuing education. Respondent was also required to pay a $15,000 fine.

FACTUAL ALLEGATIONS

9. V.H. (initials used to protect patient confidentiality) presented to Summit Medical Center on February 20, 2021 for a second trimester pregnancy termination. V.H. had previously delivered four babies by cesarean section, and her medical history included a multi-year history of tobacco use and an unknown hernia repair.

10. V.H. returned to Summit Medical Center on February 24, 2021 for completion of the abortion procedure. At that time, she confirmed compliance with relevant abortion laws, discussed the potential risks with Respondent, and provided consent for treatment.

11. Subsequently, Respondent performed a physical examination and V.H. was given misoprostol in anticipation of the dilation and evacuation procedure (D and E)[1].

12. Approximately 2 hours later, V.H. was taken to the operating room and intravenous sedation was administered. Despite the fact V.H. presented several risk factors that might pre-dispose her to hemorrhaging, Respondent did not include a vasopressin in the anesthetic mixture.[2]

13. During the procedure, Respondent was able to remove the fetal parts, but not the placental tissue. After approximately an hour, Respondent encountered excess bleeding. Respondent also reported that V.H. was lethargic and her oxygen saturation levels were dropping.

14. Respondent gave V.H. doses of Narcan and Flumazenil, but failed to take any steps to mitigate, diagnose, or treat the potential causes of V.H.'s hemorrhaging.

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[1] This procedure involves dilation of the cervix to allow the physician to remove the fetus and placental tissue from the uterus.

[2] Vasopressin has been shown to reduce the likelihood of catastrophic hemorrhage in patients undergoing a D & E.

15. Ultimately, Respondent contacted Emergency Medical Services, who transported V.H. to Sinai-Grace Hospital Emergency Department for treatment of hemorrhaging.

16. Upon arrival to the Emergency Department, staff recognized that V.H. was in hemorrhagic shock and instituted "massive transfusion protocol" to resuscitate V.H. using intravenous fluids and blood products. V.H. was transferred to the Labor and Delivery floor where she underwent an ultrasound-guided suction dilation and curettage to remove the placental tissue from her uterus.

17. Later that night, V.H. became hypotensive and tachycardic, exhibiting evidence of continued blood loss.

18. On February 25, 2021, V.H. underwent an exploratory laparotomy, and ultimately received a supracervical hysterectomy.

19. V.H. spent several days in the surgical intensive care unit and had to undergo additional transfusions and surgical procedures to address ongoing blood loss, before being transferred to the gynecological surgical unit. She was discharged after 8 days.

20. On March 10, 2021, she presented to Henry Ford Hospital with complaints of abdominal pain, that were believed to be related to her earlier medical procedures. She was transferred back to Sinai Grace and discharged with additional post operative care instructions.

COUNT I

21. Respondent's conduct as described above constitutes 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 that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession, in violation of section 16221(a) of the Code.

COUNT II

22. Respondent's conduct as described above constitutes a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs, in violation of section 16221(b)(i) of the Code.

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

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. Pursuant to section 16192(2) of the Code, Respondent is deemed to be in receipt of the complaint 3 days

after the date of mailing listed in the attached proof of service. The written response shall be submitted by email to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing to LARA-BPL-RegulationSection@michigan.gov, with a copy mailed to the undersigned assistant attorney general. If unable to submit a response by email, Respondent may submit by regular mail to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909, with a copy mailed to the undersigned assistant attorney general.

Pursuant to section 16231(9) of the Code, failure to submit a written response within the 30-day period shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully submitted,

/s/ *Bridget K. Smith*

Bridget K. Smith (P71318)
Assistant Attorney General
Licensing & Regulation Division
P.O. Box 30758
Lansing, MI 48909
Telephone: (517) 335-7569
Fax: (517) 241-1997

Dated: April 12, 2023

LF: Sharpe, Reginald D., D.O., 000436 2023-0372415-B/administrative complaint 2023-04-12

DEPARTMENT OF ATTORNEY GENERAL
LICENSING & REGULATION DIVISION

PROOF OF SERVICE

In the Matter of

Reginald D. Sharpe, D.O. Complaint No. 51-22-000436
License No. 51-01-010839

STATE OF MICHIGAN)
COUNTY OF INGHAM)

On the date below I sent a copy of: Administrative Complaint dated April 12, 2023, with Notice of Opportunity for Compliance Conference to:

Reginald D. Sharpe, D.O.

Reginald D. Sharpe, D.O.

by: (✓) First Class Mail
(✓) Certified Mail, return receipt requested
(✓) Electronic Mail

With courtesy copy to:

Michael J. Sharpe

by: ( ) First Class Mail
(✓) Electronic Mail

With copy to:

Marcie Anderson, Enforcement Division Assistant
Bureau of Professional Licensing
Department of Licensing & Regulatory Affairs

I declare that the statements above are true to the best of my information, knowledge, and belief.

Mail date: April 12, 2023

/s/ Latisha Ball-Day

Latisha Ball-Day

NOTICE OF OPPORTUNITY FOR COMPLIANCE CONFERENCE

****Completing this form DOES NOT constitute a response to the Administrative Complaint.**

You have an opportunity for a compliance conference[1]. Please select one of the following:

1. I DO NOT REQUEST A COMPLIANCE CONFERENCE ☐ (Sign and date below.)
An Administrative Hearing will be scheduled after receipt of a timely written response to the Administrative Complaint.

2. I REQUEST A COMPLIANCE CONFERENCE ☐ (Complete all information below.)

Name: Reginald D. Sharpe, D.O. File Number: 51-22-000436

Best time/day to call: ______________________________

Contact Number(s): home ____________ cell ____________ work ____________

Email: ______________________________

Comments regarding available dates:

____

____

Signature______________________________ Date:____________
(Required)

Please return to: **Department of Attorney General**
Licensing & Regulation Division
Department of Attorney General
ATTN: Bridget K. Smith
P.O. Box 30758
Lansing, MI 48909
FAX: 517-241-1997
EMAIL: smithb41@michigan.gov, balll2@michigan.gov

[1] MCL 333.16231(5) and R338.1608

LF: Sharpe, Reginald D., D.O., 000436 2023-0372415-B/Notice of Opportunity for Compliance Conference/ 2023-04-12