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

In the Matter of

BRADLEY DAVID BASTOW, D.O.
License No. 51-01-008849
_________________________________/ Complaint No. 51-17-146276

ORDER OF SUMMARY SUSPENSION

An administrative complaint has been issued against Respondent under the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 *et seq*, promulgated rules, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*.

After consideration of the documentation filed in this case and consultation with the Chairperson of the Board of Osteopathic Medicine and Surgery, the Department concludes that the public health, safety or welfare requires emergency action, as allowed by section 16233(5) of the Public Health Code and section 92(2) of the Administrative Procedures Act.

THEREFORE, IT IS ORDERED that Respondent's license to practice osteopathic medicine and surgery in the State of Michigan shall be summarily suspended commencing on the date this order is served.

Under Mich Admin Code, R 792.10702, Respondent has the right to petition for the dissolution of this order of summary suspension. This petition shall clearly state that it is a Petition for Dissolution of Summary Suspension and shall be filed with the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, Michigan 48909, with a copy served upon the Department of Attorney General, Licensing & Regulation Division, P.O. Box 30758, Lansing, Michigan, 48909. Questions concerning the Order of Summary Suspension may be directed to (517) 373-1146. Upon receipt of such a petition, an administrative hearing will immediately be scheduled before an administrative law

judge, who shall dissolve the order of summary suspension unless sufficient evidence is produced to support a finding that the public health, safety, or welfare requires emergency action and a continuation of the suspension order.

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

By: ____________________
Kim Gaedeke, Director
Bureau of Professional Licensing

Dated: 05/12/2017

LF: 2017-0180499-B\Bastow, Bradley David, D.O., 146276\Pleading – Order Summary Suspension – 2017-05-12

STATE OF MICHIGAN
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_________________________________/

ADMINISTRATIVE COMPLAINT

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

1. The Board of Osteopathic and Medical Surgery, an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee.

2. Respondent is currently licensed to practice as an osteopathic physician pursuant to the Public Health Code. At all times relevant to the complaint, Respondent owned and operated Body Laser Sculpting Medical Spa located in Glenn, Michigan.

3. Section 16215(1) of the Public Health Code provides that a licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training, or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee's profession and will be performed under the

licensee's supervision. A licensee shall not delegate an act, task, or function under this section if the act, task, or function, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of the licensee under this article.

4. Section 16221(a) of the Code provides the Disciplinary Subcommittee with authority to take disciplinary action against 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 practice as a physician.

5. Section 16221(b)(i) of the Code provides the Disciplinary Subcommittee with the authority to take disciplinary action against a licensee for 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 from the health profession, whether or not actual injury to an individual occurs."

6. Section 16221(b)(vi) of the Code provides the Disciplinary Subcommittee with authority to take disciplinary action against a licensee for lack of good moral character, defined at section 1 of 1974 PA 381, as amended; MCL 338.41 *et seq*, as the "propensity on the part of the person to serve the public in the licensed area in a fair, honest and open manner."

7. Section 16221(h) of the Code authorizes the DSC to take disciplinary action against a licensee for violating, or aiding and abetting in a violation of, Article 15 or a rule promulgated under Article 15.

8. Section 16233(5) of the Public Health Code provides for the summary suspension of a license, reading, in pertinent part, as follows:

> After consultation with the chair of the appropriate board or task force or his or her designee, the department may summarily suspend a license or registration if the public health, safety, or welfare requires emergency action in accordance with section 92 of the administrative procedures act of 1969, being section 24.292 of the Michigan Compiled Laws. If a licensee or registrant is convicted of a felony; a misdemeanor punishable by imprisonment for a maximum term of 2 years; or a misdemeanor involving the illegal delivery, possession, or use of a controlled substance, the department shall find that the public health, safety, or welfare requires emergency action and, in accordance with section 92 of the administrative procedures act of 1969, shall summarily suspend the licensee's license or the registrant's registration.

9. Section 16226 of the Code authorizes the Disciplinary Subcommittee to impose sanctions against persons licensed by the Board if, after 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.

ALLEGATIONS

C.R.

10. On April 20, 2017, C.R. (initials used to protect patient confidentiality) went to Respondent's Glenn facility for liposuction. The procedure began at approximately 11 a.m. and lasted until approximately 9 p.m.

11. D.G. assisted Respondent during the procedure. D.G. is not a licensed health professional and has no medical training or background. Despite that, Respondent delegated portions of C.R.'s care to D.G., including administering shots of Demerol, a schedule II controlled substance.

12. As part of the April 20, 2017 procedure, Respondent removed fat from under C.R.'s skin. C.R. and her mother observed Respondent pouring the fat down the facility's regular sink drain, as opposed to properly disposing of the biological waste either in a biohazard storage container or via a sterile sewage system.

13. Respondent stored the remaining fat from C.R.'s procedure in baggies that were placed in a clear plastic container without a lid and with no biohazard markings or symbols.

14. C.R.'s mother and sister were allowed to sit with C.R. during the liposuction procedure. At one point, they became concerned because C.R. appeared to be drowsy and going in and out of consciousness. As a result, the family contacted Allegan County Central Dispatch for an ambulance.

15. Allegan County Fire and Sheriff's Departments responded to the Glenn facility.

16. C.R. was taken to the hospital for observation and the Allegan County Sheriff's Department began an investigation of Respondent's practice and facility.

<u>Glenn Facility</u>

17. From approximately 2015 until at least April 20, 2017, Respondent operated his practice inside an unfinished pole barn.

18. On June 15, 2016, the 57th District Court entered a judgment against Respondent ordering that he bring the Glenn facility property into compliance with the site plan approved by the Township within 30 days.

19. The Court also ordered that no activity other than site construction could occur on the property until the Township issued a certificate of occupancy.

20. Despite the Court's order, Respondent continued to run his practice out of the Glenn facility until at least April 20, 2017.

21. As of April 21, 2017, the township had not issued a certificate of occupancy for the property.

22. In addition, pictures obtained by the Sheriff's Department pursuant to a search warrant and a subsequent inspection by a Department Pharmacy Inspector demonstrate:

a. Respondent failed to maintain sanitary conditions in his facility.

b. Respondent improperly stored medical waste.

c. Respondent failed to properly store medications including controlled substances.

d. Respondent is improperly dispensing and recording the dispensing of prescription medications, including controlled substances.

e. Respondent allowed staff to dispense controlled substances when he was not present at the facility.

f. Respondent failed to separate the expired drugs from the non-expired drugs.

g. Respondent improperly comingled human and animal use drugs.

h. Respondent failed to properly secure controlled substances maintained at his facility.

24. During a May 10, 2017 inspection of the Glenn Facility Respondent admitted to the Department Inspector that he had been taking Tramadol, a schedule IV controlled substance, from the facility for personal use.

COUNT I

25. Respondent's conduct as described above constitutes negligence, failure to exercise due care and negligent delegation of duties in violation of section 16221(a) of the Code.

COUNT II

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

COUNT III

27. Respondent's conduct as described above constitutes a lack of good moral character in violation of section 16221(b)(vi) of the Code.

COUNT IV

28. Respondent's conduct as described above constitutes improper delegation contrary to section 16215 of the Code in violation of section 16221(h) of the Code.

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

FURTHER, Complainant requests that pending the hearing and final determination Respondent's license to practice as a doctor in the State of Michigan continue to be summarily suspended pursuant to section 92 of the Administrative Procedures Act and section 16233(5) of the Public Health Code for the reason that, based

upon the allegations set forth herein, to permit Respondent to continue to practice the profession constitutes a danger to the public health, safety and welfare requiring emergency action.

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

Respectfully Submitted,

BILL SCHUETTE
Attorney General

Michelle M. Brya P66861
Division Chief

Bridget K. Smith P71318
Assistant Attorney General
Licensing & Regulation Division
525 W. Ottawa, 3rd Floor, Wms Bldg
P.O. Box 30758
Lansing, Michigan 48909

Dated: May 12, 2017

LF: 2017-0180499-B\Bastow, Bradley David, D.O., 146276\Pleading – Administrative Complaint SS – 2017-05-12