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

In the Matter of

TODD NEAL ROSEN, M.D.
License No. 43-01-049464
_____/

Complaint No. 43-18-152789

CONSENT ORDER AND STIPULATION

CONSENT ORDER

An administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on June 11, 2019, charging Todd Neal Rosen, M.D. (Respondent) with having violated sections 16221(a) and (b)(i) of the Public Health Code, MCL 333.1101 *et seq.*

The parties have stipulated that the Disciplinary Subcommittee may enter this consent order. 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 that Respondent has violated section 16221(a) of the Public Health Code.

Accordingly, for these violations, IT IS ORDERED:

Respondent is FINED Twenty-Five Thousand and 00/100 Dollars ($25,000.00) to be paid by check, money order, or cashier's check made payable to the State of Michigan (with complaint number 43-18-152789 clearly indicated on the check or money order), and shall be payable within sixty (60) days of the

effective date of this order. The timely payment of the fine shall be Respondent's responsibility. Respondent shall mail the fine to: Department of Licensing and Regulatory Affairs Bureau of Professional Licensing, Enforcement Division, Compliance Section, P.O. Box 30189, Lansing, Michigan 48909.

Count II of the complaint, alleging a violation of section 16221(b)(i) of the Public Health Code, is DISMISSED.

Respondent shall direct any communications to the Department that are required by the terms of this order to: Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Enforcement Division, Compliance Section, P.O. Box 30670, Lansing, Michigan 48909.

Respondent shall be responsible for all costs and expenses incurred in complying with the terms and conditions of this consent order.

Respondent shall be responsible for the timely compliance with the terms of this consent order, including the timely filing of any documentation. Failure to comply within the time limitations provided will constitute a violation of this order.

This order shall be effective thirty days from the date signed by the Chairperson of the Disciplinary Subcommittee or the Disciplinary Subcommittee's authorized representative, as set forth below.

Signed on 1-15-2021

MICHIGAN BOARD OF MEDICINE

By _____
Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate as follows:

1. Respondent does not contest the allegations of fact and law in the complaint. Respondent understands that, by pleading no contest, he does not admit the truth of the allegations but agrees that the Disciplinary Subcommittee may treat the allegations as true for resolution of the complaint and may enter an order treating the allegations as true.

2. Respondent understands and intends that, by signing this stipulation, he is waiving the right under the Public Health Code, rules promulgated under the Public Health Code, and the Administrative Procedures Act of 1969, MCL 24.201 *et seq.*, to require the Department to prove the charges set forth in the complaint by presentation of evidence and legal authority, and to present a defense to the charges before the Disciplinary Subcommittee or its authorized representative. Should the Disciplinary Subcommittee reject the proposed consent order, the parties reserve the right to proceed to hearing.

3. The Disciplinary Subcommittee may enter the above Consent Order, supported by Board conferee Richard D. Bates, M.D. Dr. Bates or an attorney from the Licensing and Regulation Division may discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

4. Dr. Bates and the parties considered the following factors in reaching this agreement:

   A. Respondent does not manually write prescriptions. He believes that the transmission of dual prescriptions was the result of a

malfunction of his electronic medical records system computer, which he says appears to have auto-generated a copy of the earlier scrips which Respondent says he had deleted. Respondent also notes that he is an expert with computer electronic medical record systems.

B. Respondent states that when the pharmacy received the dual scrips, it contacted Respondent's office to ask for instructions as to how to fill them, and that the nurse who answered the call, without consulting Respondent or checking the medical record, told the pharmacy to fill both, despite having been trained by Respondent always to consult him or check the medical record upon receipt of such calls from pharmacies.

C. Respondent, at the November 7, 2016 patient consultation, clearly stated to the patient, his legal guardian, and his foster care home direct care provider that the amount of lithium to be administered was to be reduced. The transmission of this instruction is corroborated not only by Respondent's patient notes but by a notarized affidavit from the patient's legal guardian.

D. Respondent has been licensed since 1984 and, in a distinguished career providing psychiatric care to underserved communities, has never previously been disciplined.

By signing this stipulation, the parties confirm that they have read, understand, and agree with the terms of the consent order.

AGREED TO BY:

Bruce Charles Johnson (P62645)
Assistant Attorney General
Attorney for Complainant
Dated: December 6, 2019

AGREED TO BY:

Todd Neal Rosen, M.D.
Respondent

Dated: 12-2-19

Karen M. Faett (P41609)
Attorney for Respondent
Dated: 12/5/19

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

In the Matter of

TODD NEAL ROSEN, M.D.,
License No. 43-01-049464 Complaint No. 43-18-152789
_____/

ADMINISTRATIVE COMPLAINT

Attorney General Dana Nessel, through Assistant Attorney General Bruce Charles Johnson, on behalf of the Department of Licensing & Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Todd Neal Rosen, M.D. (Respondent), alleging upon information and belief as follows:

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

2. Respondent is currently licensed to practice medicine pursuant to the Public Health Code. At all times relevant to this Complaint, Respondent practiced as a psychiatrist with Genesee County Community Mental Health.

3. Section 16221(a) of the Code authorizes the DSC to discipline licensees for "violation of a 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."

4. Section 16221(b)(i) of the Code provides the DSC with authority to take disciplinary action against Respondent for incompetence, defined at section 16106(1) 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 a licensee if, after an opportunity for a hearing, the Disciplinary Subcommittee determines that the licensee violated one or more of the subdivisions contained in section 16221 of the Code.

FACTUAL ALLEGATIONS

6. In the autumn of 2016, Respondent provided psychiatric care to B.B. (initials used to protect patient confidentiality), a 41-year-old male suffering from schizophrenia.

7. On October 10, 2016, Respondent prescribed lithium for B.B., with the prescribed dosage being a 600 mg. capsules to be taken by mouth twice a day.

8. On October 17, 2016, Quest Diagnostics, at the request of Respondent, tested B.B.'s lithium level and found it to be 0.9, which is within the normal range.

9. On November 7, 2016 Respondent, having been told that B.B.'s lithium dosage needed to be lowered, conducted a medication review for B.B.

10. Respondent failed to document the medication review.

11. Respondent, at the conclusion of the medication review, wrote out two lithium prescriptions for B.B.: one identical to the prior one, with the prescribed dosage being a 600 mg. capsules to be taken by mouth twice a day, and one for lithium carbonate extended release, with two 450 mg. tablets to be taken at bedtime. Both prescriptions were sent to the pharmacy. The effect of the two prescriptions was to nearly double B.B.'s lithium dosage.

12. Respondent claims that his intent was actually to discontinue the earlier prescription, and for B.B. to take only the second prescription, for the two 450 mg. tablets at bedtime. He asserts that sending both prescriptions to the pharmacy was a clerical error, and that he gave clear written and oral instructions to staff both at the clinic and at the adult foster care home where B.B. resided that that B.B. was to receive only two 450 mg. capsules at bedtime.

13. No records exist of such purported written instructions, and staff of the adult foster care home deny that Respondent gave them any such oral instructions.

14. When the pharmacy received the two prescriptions, pharmacy staff called Genesee Health Systems to verify that the prescription amounts were correct. After making the call, they appended a handwritten note to the prescription for the 600 mg. capsules stating, "give in a.m. and afternoon per Jeff @ GHS," and appended a handwritten note to the prescription for the 450 mg. capsules, "give this dose at bedtime per Jeff @ GHS."

15. Neither of the prescriptions was withdrawn. The manager of the adult foster care home states that, per the handwritten notes from the pharmacy, her understanding was that B.B. was to receive medication from both prescriptions.

16. On November 16, 2016, the manager of the adult foster care home observed that B.B. was exhibiting symptoms of impaired speech and motor control. She also noted that over the previous two weeks, he had exhibited growing signs of mental confusion.

17. The symptoms grew worse over the next day, and on November 17, 2016, adult foster care home staff arranged for B.B. to be transported to the McLaren Regional Medical Center Emergency Department, where he was found to be suffering from tremor, agitation, and restlessness, and to have a lithium level of 2.9, an extremely elevated level.

18. McLaren staff discontinued the two lithium prescriptions that Respondent had written on November 7, and undertook steps to reduce his lithium level. Although they were successful in reducing his lithium level to 0.5, a normal reading, by that time, he was exhibiting other severe symptoms, including acute renal failure, metabolic encephalopathy, and cardiac arrest, and required intubation to be kept alive.

19. On November 22, B.B.'s treating physician concluded that he remained intubated and unresponsive, and that he had a grave prognosis for the possibility of "meaningful functional neurologic recovery." At that time, his family decided to extubate him and to allow his condition to run its course.

20. B.B. died at 11:08 p.m. that night. His death certificate listed the cause of death as being "complications of lithium toxicity."

COUNT I

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

COUNT II

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

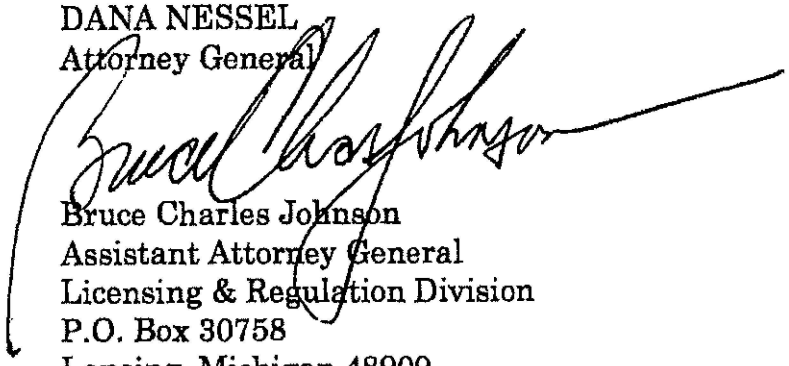
THEREFORE, Complainant requests that this Complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced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

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from the 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 the transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully submitted,

DANA NESSEL
Attorney General



Bruce Charles Johnson
Assistant Attorney General
Licensing & Regulation Division
P.O. Box 30758
Lansing, Michigan 48909
(517) 335-7569

Dated: June 11, 2019

LF: 2019-0247655-B/Rosen, Todd Neal, M.D., 152789/Complaint – Administrative – 2019-05-30