BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

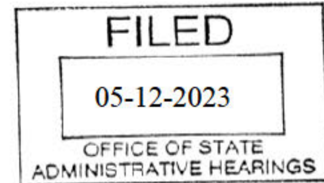
GEORGIA COMPOSITE MEDICAL BOARD,
Petitioner,

v.

MELVIN PERRY, MD,
Respondent.

Docket No.: [redacted]
[redacted]-OSAH-GCMB-PHY-33-Barnes

Agency Reference No.: [redacted]



INITIAL DECISION

Petitioner, the Georgia Composite Medical Board ("Board") brought this action seeking the imposition of sanctions against Respondent's license to practice medicine in Georgia. The evidentiary hearing took place before the undersigned administrative law judge on April 12, 2023. The Board was represented by Sandra Bailey, Esq., Assistant Attorney General. Respondent was represented by Brian Trulock, Esq., and Marie Wilcox, Esq. The undersigned heard testimony from Agent Cameron Rabbitt, Kristin Howe, E[redacted] C[redacted], Christa Summers, and Respondent. After careful consideration of the evidence and the arguments of the parties, and for the reasons stated below, the Board's decision to impose sanctions against Respondent's license to practice as a physician is **REVERSED**.

I. FINDINGS OF FACT

1. Respondent is licensed to practice medicine in the state of Georgia and was licensed as such at all times referenced in this Decision. Respondent's specialties are pediatrics and pediatric critical care medicine. Respondent is also currently licensed to practice medicine in Louisiana. (Statement of Matters Asserted; Exhibit P-1; Testimony of Cameron Rabbitt).

2. Respondent received his bachelor's degree in microbiology with honors from Louisiana State University. He subsequently attended medical school at Louisiana State University's New Orleans campus. He completed his residency in pediatrics at the Children's Hospital in New Orleans,

followed by a fellowship in critical care medicine at the Medical College of Georgia. He has been board-certified in pediatrics since 1999 and in critical care medicine since 2002. Additionally, he holds certifications in basic life support and in pediatric intensive life support. (Testimony of Respondent).

3. Following his fellowship, Respondent joined the faculty at Emory School of Medicine, and later worked at Children's Healthcare of Atlanta (CHOA). After that, he spent approximately twelve years doing locum tenens work, meaning he acted as a substitute for physicians who were on extended leave. He practiced across the country, at one point holding as many as twelve licenses at once. However, he still maintained a permanent residence in Georgia. (Testimony of Respondent).
4. At some point during that period Respondent practiced at the Wilford Hall medical center, which is located at an Air Force base in Texas. In that role he performed critical care work, primarily treating very sick children—both children from the local community as well as airmen's children. He was also the medical director in charge of the transport (both air and ground) of critically ill individuals both back to the U.S. from overseas and within the U.S. (Testimony of Respondent).
5. Respondent returned permanently to Georgia in 2020 and established his own practice, Total Care Pediatrics, in Austell, Georgia. (Testimony of Respondent).

Patient S.C.

6. On July 15, 2019, E C brought her then 20-month-old daughter, S.C., to the Children's Clinic in Newnan, Georgia, where Respondent was working as a locum tenens physician. (Testimony of E C; Testimony of Respondent).
7. S.C. had initially developed a fever of 103 degrees the prior Saturday afternoon. The fever was initially reduced with Motrin. Ms. C consulted with her brother-in-law, a physician's

assistant, who advised her to continue to monitor the fever. She grew alarmed when, after checking S.C.'s temperature just past midnight, she had a temperature of 106 degrees.[1]

8. Ms. C[redacted] and her husband agreed that they did not have time to travel to the hospital, which was 20 minutes away, and instead decided to put S.C. in a cool bath to bring the fever down; she recalled a time when one of her older children had a 105-degree fever, and his doctor had advised her to do this. After around 45 minutes, S.C.'s temperature had gone down to 100 degrees. (Testimony of Ms. C[redacted]).

9. By around 5:45 a.m. Sunday morning, S.C.'s temperature had spiked back up, so Ms. C[redacted] took her to Summit Urgent Care in Newnan at around 7:30 a.m. The healthcare provider she saw at the clinic suspected a urinary tract infection (UTI) and recommended that Ms. C[redacted] take S.C. to her primary care on Monday so that a urine culture could be taken. In the meantime, they prescribed Suprax, an antibiotic. The clinic did not recommend emergency care at that point. (Testimony of Ms. C[redacted]).

10. Ms. C[redacted] recalled that Suprax did not work as quickly as she hoped. In her experience with her older children, she knew that antibiotics tended to result in rapid improvement, but she estimated that S.C. was only around 50% better. However, she determined that S.C. was definitely not acutely ill—for example, she was eager to go play with her older siblings on Sunday afternoon. (Testimony of Ms. C[redacted]).

11. Early Monday morning, Ms. C[redacted] left a message at the Children's Clinic, S.C.'s regular pediatrician's office, explaining S.C.'s illness. S.C. did not seem to be in any particular distress that morning, but Ms. C[redacted] said she felt "uneasy." She called the clinic again and let them know she was on her way. (Testimony of Ms. C[redacted]; Testimony of Patti Ferguson).

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[1] Ms. C[redacted] stated that from past experience she knew that the particular thermometer she used always read one degree higher, so she estimated that S.C.'s actual temperature was 105 degrees.

12. Ms. C[redacted] arrived at the Children's Clinic at around 8:45 a.m., where she was told that S.C. would be seen by Respondent, instead of their usual doctor. Ms. C[redacted] asked if they could see Shannon, a physician's assistant, who had treated her kids before, but she was not available. (Testimony of Ms. C[redacted]).

13. Ms. C[redacted] and S.C. were taken to an exam room. A nurse took S.C.'s vitals, and Ms. C[redacted] recalled that her temperature was only slightly elevated. (Testimony of Ms. C[redacted]).

14. Respondent came into the exam room, introduced himself, and asked Ms. C[redacted] what was going on with S.C. Ms. C[redacted] noticed that he looked at her the whole time, and "didn't even look" at S.C. at all. At one point, he interrupted her and was "very angry," "scolding" Ms. C[redacted] for not taking S.C. to the hospital. He pointed at her and told her she made a "terrible, terrible mistake." Ms. C[redacted] described the tone of his voice as "almost a yell." Respondent testified that they both raised their voices. (Testimony of Ms. C[redacted]; Testimony of Respondent).

15. Ms. C[redacted] testified that she started to say, "I'm sorry you don't agree with our parental judgment," but Respondent interrupted and said "You could've killed your daughter, you could have cost her her life." Ms. C[redacted] says she asked that he speak to her respectfully and says she "begged" him to just look at S.C. Based on how S.C. was acting, Ms. C[redacted] did not think that going to the emergency room was warranted.

16. Respondent conceded that he is "not a shrinking violet," and that "people sometimes take offense to that." He says that he told Ms. C[redacted] that her actions could have resulted in S.C.'s death, but denies saying, "You almost killed your daughter." (Testimony of Respondent).

17. Ms. C[redacted] asked Respondent whether she could see Shannon, saying, "I didn't want to see you anyway." According to Ms. C[redacted], Respondent said she could not see Shannon, and in

fact, she was no longer a patient at the Children's Clinic and that she needed to "get out." Respondent denies that he "fired" Ms. C[redacted] from the practice. (Testimony of Ms. C[redacted]; Testimony of Respondent).

18. Patti Ferguson was in her office behind the front desk while Respondent was meeting with Ms. C[redacted]. She recalls hearing raised voices, particularly Respondent's. She added that she typically cannot hear voices in the exam rooms from her office. After a few minutes, she decided to go and see what was going on, but by then Ms. C[redacted] and Respondent were heading towards her. (Testimony of Ms. Ferguson).

19. Ms. C[redacted] went to the checkout desk and spoke with Patti Ferguson, the office manager. Ms. C[redacted] asked her whether Shannon could see S.C. Ms. C[redacted] was crying at this point. Ms. Ferguson asked Respondent and he said "absolutely not." Ms. Ferguson noted that his voice was "raised" and that he was not screaming, but was "louder than normal." Ms. Ferguson said she had to stand by Respondent's decision. (Testimony of Ms. C[redacted]; Testimony of Patti Ferguson).

20. Ms. C[redacted] testified that Respondent did not examine S.C. or even look at her. She also says that, although he chastised her for not taking S.C. to the hospital, he did not explicitly tell her "you need to take her to the hospital." She says he did not provide any instructions for S.C.'s care at all. (Testimony of Ms. C[redacted]).

21. At the hearing, Respondent explained that, in a situation where a baby had such a persistently high fever, was not responding to antibiotics, and was "not acting like a toddler should act," his concern was that she had a UTI that was at risk of moving into the kidneys, resulting in a condition called pyelonephritis. This was concerning to Respondent because pyelonephritis could lead to sepsis. Respondent was especially concerned about S.C. developing sepsis, because the death rate from sepsis in pediatric patients approaches 50 percent. He explained that his approach was to "look at

what may kill you first instead of what may kill you last," acknowledging that he looks at things differently than some other physicians.[2] (Testimony of Respondent).

22. Respondent testified that, had Ms. Ferguson told him about Ms. C[redacted]' situation prior to seeing her, he would not have let them in in the first place. The Children's Clinic did not have the resources required to treat S.C. Specifically, he could not take urine cultures or blood samples. He added that Piedmont Newnan Hospital was a ten-minute drive away from the Children's Clinic, and under federal law was required to accept walk-ins. (Testimony of Respondent).
23. Respondent does not believe he accepted S.C. as his patient that day. (Testimony of Respondent).
24. Respondent did not see the need to call an ambulance for S.C., or to call Piedmont Newnan Hospital and let them know she would be arriving soon, because, as he explained, S.C. was not "critical," even as she did need a more advanced level of care to treat her illness. (Testimony of Respondent).
25. After leaving the Children's Clinic, Ms. C[redacted] did not take S.C. to the hospital immediately, but instead tried to find a primary care doctor who would accept a new patient for a sick appointment. She eventually got an appointment with a doctor in Tyrone, Georgia. That doctor gave her something to put in S.C.'s diaper that would hopefully catch a urine sample. (Testimony of Ms. C[redacted]).
26. At around 3 p.m., as Ms. C[redacted] was driving home from Tyrone, S.C. began crying and screaming. Up until that point, S.C. had not been in distress and her fever had stayed consistently at 100 degrees. But at this point "the picture changed." She took S.C. to Piedmont Newnan

[2] Respondent said that he did not explain any of this to Ms. C[redacted]. He implied that he believed it would not have been useful because she "had already been ignoring medical advice." When asked why he would say that she had already been ignoring medical advice, he answered: "because based on when I talked to her with -- despite her with all these doses of Tylenol and Motrin this is my first time hearing it, she just told me that the baby was -- she just did cold baths." (Testimony of Respondent).

Hospital. There, medical staff took blood and urine samples and officially diagnosed her with a UTI. Eventually S.C. was transported to CHOA via ambulance, where she spent two nights receiving intravenous antibiotics. S.C.'s medical records from CHOA indicate that she was diagnosed with acute pyelonephritis. (Testimony of Ms. C[redacted]; Exhibit P-8).

27. The same day that Ms. C[redacted] visited the Children's Clinic, her husband, Josh C[redacted], made a complaint to the Board about Respondent. (Testimony of Ms. C[redacted]; Exhibit P-6; Testimony of Agent Rabbitt).

28. Dr. Ann Contrucci, a pediatrician, performed a medical records review of S.C.'s case on behalf of the Board. Her review was limited to the note Respondent wrote following S.C.'s visit to the Children's Clinic. (Testimony of Dr. Contrucci; Exhibit P-7).

29. Dr. Contrucci testified that Respondent's medical note regarding S.C. was incomplete. She therefore concluded that Respondent's treatment of S.C. fell below the professional standard of care. (Testimony of Dr. Contrucci).

30. The top part of S.C.'s medical note was completed by the nurse. It listed her temperature, weight, and the medications she had taken. It also contained a brief note describing the history of her illness: that she had developed a fever on Saturday that had risen to 106 degrees at its peak, and that she had gone to Urgent Care on Sunday. At the bottom of the page, Respondent had written a note that said something along the lines of: "Patient was to be seen after high fever of 106 degrees. Mom did not take patient to ER . . . When mom was informed of the . . . dangers she said that 'it was a parent judgment call.' This MD was uncomfortable with mom['s] reaction and defiance of medical advice . . . Mom was instructed that this office is not the appropriate level of care. Mom was instructed to go to the Emergency Department, as we cannot get lab results back in a timely enough manner in office. Mom disregarded and went to another pediatric office, who contacted

this office about transferring records." Dr. Contrucci criticized this note as not having been written in real time, as it was clearly not written until after the other pediatrician's office called the Children's Clinic. (Exhibit P-7; Testimony of Dr. Contrucci; Testimony of Respondent).

31. Dr. Contrucci explained that, particularly in pediatrics, looking at a patient is very important because a physician can glean a lot of information from a visual observation. She would also have conducted a basic physical exam. She says that meeting the standard of care requires at least a working assessment, and there is no indication that Respondent conducted any exam at all. Dr. Contrucci believes that "if it's not recorded, it didn't happen," and that the "bare minimum" level of care is to document a patient's visit and assessment." (Testimony of Dr. Contrucci).

32. Dr. Contrucci believes that a physician-patient relationship had formed between Respondent and S.C. She believes that such a relationship forms the moment a physician walks into an exam room where a patient is waiting. She conceded that if no physician-patient relationship is formed, a doctor does not have an obligation to write a note for a patient. (Testimony of Dr. Contrucci).

33. Respondent denies that he formed a physician-patient relationship with S.C. Therefore, he had no obligation to write a note for her. (Testimony of Respondent).

The Walmart Incident

34. The following incident occurred on December 5, 2019, in a Newnan, Georgia Walmart parking lot. (Testimony of Christa Summers, Testimony of Respondent).

35. Christa Summers had gone to Walmart that day at around noon to pick up an online order. As she was leaving, she was preparing to drive past the front of the store where shoppers enter and exit. The car in front of her unexpectedly stopped to pick up a passenger. Ms. Summers chose to drive around the car. She says she looked around before passing and did not see anyone. She estimates that she was moving at around five miles per hour as she moved to the left of the stopped vehicle.

As she was moving back into her lane, she heard a crash and her car shook. At first she did not know what could have caused the crash and worried that she had hit something. (Testimony of Ms. Summers).

36. Ms. Summers said she saw Respondent and a turned-over shopping cart. His arms were up in the air, and he was yelling. Still not sure what had happened, Ms. Summers pulled over and called 911. Respondent seemed to have left the area, but she was afraid to get out of her car. (Testimony of Ms. Summers).
37. Respondent explained that after he parked at Walmart that day, he took a cart from a shopper who had finished using it and started walking towards the front of the store. He saw Ms. Summers and made eye contact with her. As he began to cross in front of the store, Ms. Summers pulled to the left of the stopped car, into the lane where Respondent was walking. Respondent says that he pushed the cart away from him and put his hands up in the air to avoid being hit. He added that he did not intentionally push the cart into Ms. Summers' car. (Testimony of Respondent).
38. Respondent says that he could see Ms. Summers was calling the police and, wanting to avoid a confrontation, he went inside the store to do his shopping. (Testimony of Respondent).
39. An officer arrived at the scene quickly. Once she got out of her car, Ms. Summers saw the damage on her driver's side passenger door. The officer went inside the Walmart to find Respondent—Ms. Summers had told him that Respondent had been wearing khaki scrubs. After the officer found Respondent, he asked Ms. Summers how much damage she estimated had been done to her car. When she told him she thought it was around $500, he arrested Respondent. (Testimony of Ms. Summers; Testimony of Agent Rabbitt).
40. Subsequently, Respondent swore out a warrant for attempted vehicular homicide, which Ms. Summers received the following January. However, Respondent admitted that he did not

necessarily think that Ms. Summers had intentionally tried to kill him. (Testimony of Ms. Summers; testimony of Respondent).

Kristin Howe

41. The following incident occurred on July 21, 2022, at Respondent's office, Total Care Pediatrics, in Austell, Georgia. (Testimony of Respondent; Testimony of Kristin Howe).

42. Respondent was treating a two-month-old baby who had come into his office that day with difficulty breathing. She was hypoxemic, meaning she had low blood oxygen levels. Respondent had treated her with oxygen, albuterol, and steroids. Respondent was in the process of weaning the patient slowly off of the supplemental oxygen, noting that she had been stable in his office for "hours" by that evening. Because it was getting late, Respondent wanted to have the baby transported to CHOA while she was stable enough. He called the non-emergency services number, but his call was bumped up to emergency-level due to internal dispatch protocol. (Testimony of Respondent).

43. Kristin Howe, a paramedic for Puckett EMS, testified that her truck was dispatched to Respondent's office for an infant with difficulty breathing. (Testimony of Ms. Howe).

44. The fire department arrived at Respondent's office first. Respondent told the firefighters to leave because he did not need them. He testified that he was particularly concerned about having a lot of authorities around his office because many of his patients have documentation issues, and might not feel comfortable going into his building with the firetruck blocking the entrance. The firefighters responded that Puckett EMS had told them to stay. (Testimony of Respondent).

45. When Puckett EMS arrived, Respondent says he saw Ms. Howe arrive with two colleagues and start "yanking" at the door, which was kept locked due to COVID-19 protocols. Ms. Howe testified that when she arrived and knocked at the door, she could see Respondent through the glass calling

the police to report that the fire department was trespassing. (Testimony of Ms. Howe; Testimony of Respondent).

46. Respondent took Ms. Howe and the other two paramedics to a patient room, where his patient was sitting in her mother's lap, receiving supplemental oxygen through nasal canula tubing. Ms. Howe walked into the room and immediately asked the baby's mother, in Spanish, whether the baby had eaten. Respondent says that at no point did paramedics ask him anything about the child's history, or allow him to say anything.
47. According to Ms. Howe, Respondent told the paramedics that he had already called the report in to the hospital so that it would expect the baby's arrival but did not tell them which hospital. Respondent directed the infant's mother to place her on the paramedics' stretcher, which was positioned just outside the exam room. However, Ms. Howe told her to put the baby in her car seat instead, which they could then strap onto the stretcher. Respondent explained that he had wanted to put the baby on the stretcher directly, because having her in the car seat could impact her breathing. Ms. Howe testified that putting the baby in the car seat would keep her more secure during transport. Respondent says that Ms. Howe overruled him and told the mother to put the baby in the car seat. (Testimony of Ms. Howe; Testimony of Respondent).
48. Ms. Howe says that she is tasked with transporting a child that young at least once a week. (Testimony of Ms. Howe).
49. Once the child was in the car seat, Respondent wanted to check her vitals again to make sure she was still stable. He was "alarmed" that her heart rate was a "very high" 215. A heart rate that high could lead to injury to the child's heart. (Testimony of Respondent).
50. Respondent also wanted to check the baby's oxygen levels. Ms. Howe and her coworkers attempted to use a traditional "clip-on" pulse oximeter, which is normally meant to clip to an

adult's finger. At the hearing, Ms. Howe explained that the protocol for using that device on infants is to clip it onto the child's big toe, and then pull the baby's sock over the device so that it stays on. Ms. Howe says that the baby kicked the pulse oximeter off before they could get the sock over it, but that she saw it provide a reading of 100% oxygen saturation. She believed that number was reliable. (Testimony of Respondent; Testimony of Ms. Howe).

51. Respondent explained that the FDA and pulse oximeter's manufacturer do not recommend using the clip-on pulse oximeter on babies or infants, because they are designed to need a certain amount of blood flow in order to give a proper reading. (Testimony of Respondent).
52. Respondent said that the "older" of the three EMTs kept trying to get the clip on. Unlike Ms. Howe, Respondent was not comfortable trusting the reading from the device. He added that he does not personally recall seeing the 100 percent result. Instead, Respondent wanted to use a "band-aid" oxygen monitor, which comes in the form of a small strip that wraps around a baby's finger. Ms. Howe says that her supervisor went to their truck to see whether they had a band-aid oxygen monitor, but Respondent says that no one told him that. Respondent had an oxygen monitor in his office.[3] (Testimony of Respondent; Testimony of Ms. Howe).
53. According to Ms. Howe, Respondent told her that, because she did not have the right equipment, he would transport the baby himself (presumably in his own vehicle). Ms. Howe says she asked the child's mother whether she wanted to go in the ambulance. She says Respondent started yelling, insisting that he was taking the baby with him. (Testimony of Ms. Howe).
54. Respondent, however, stated that he was growing increasingly concerned about the child's stats as the EMTs continued to attempt to make the clip-on pulse oximeter stay on. Wanting to bring the baby back into the exam room to be stabilized, he reached over to unclip the baby from her car

[3] Ms. Howe's truck was not equipped with a band-aid oxygen monitor that day. However, she testified that they were not legally required to carry one because, according to her, the regular clip-on works well enough.

seat, and Ms. Howe hit his hand. Respondent said nothing but reached over again, and Ms. Howe hit his hand away again. (Testimony of Respondent).

55. Respondent was at this point still holding the oxygen tank. Ms. Howe says she reached over and removed the nasal canula tubing (which was still attached to the infant) from the oxygen tank so that they could leave. It is not clear how Ms. Howe intended to continue providing the child with oxygen. (Testimony of Respondent; Testimony of Ms. Howe).
56. Ms. Howe says that as she was reaching for the oxygen tubing Respondent "shoved" her back with both hands, while Respondent testified just that he "pushed her hand away." She said "boy, don't you ever touch me," to which he responded "bitch, don't call me boy." Ms. Howe denied that she used "boy" as a racial pejorative, but rather that she said it because he was "throwing a temper tantrum." (Testimony of Respondent; Testimony of Ms. Howe).
57. Ms. Howe says that Respondent began reaching for the baby, and Ms. Howe stepped up and put her arm out, "and that's when we ended up fighting to the floor." In contrast, Respondent recalls that Ms. Howe ran around the stretcher towards him, and he held out his right arm and pushed her away. He says that she lost her footing and grabbed the sleeve of his sweatshirt, dragging him down with her and ripping his sleeve. (Testimony of Respondent; Testimony of Ms. Howe).
58. Ms. Howe says that Respondent ended up on top of her, but that she fought him off and he fell over to her left. Although Respondent still had the oxygen tank in his hand, Ms. Howe denies that he tried to hit her with it. Respondent says that Ms. Howe's coworker jumped on top of him, and that Respondent kicked him away. According to Ms. Howe, the entire altercation lasted around 10 to 15 seconds. Ms. Howe says she got off the ground first, while Respondent says that he did. (Testimony of Respondent; Testimony of Ms. Howe).
59. One of Ms. Howe's coworkers called the police, who arrived around two or three minutes later

and arrested Respondent. Ms. Howe did not make any complaints to the Board. (Testimony of Respondent; Testimony of Ms. Howe; Testimony of Agent Rabbitt).

60. The Board initiated an investigation into Respondent following an article in the Atlanta Journal-Constitution about this incident. As part of his investigation, Agent Rabbitt interviewed Ms. Howe. He also looked for a history of quality of care complaints about Respondent, which is when he found the complaint from Ms. C[redacted]. (Testimony of Agent Rabbitt).

61. On July 26, 2022, Agent Rabbitt visited Puckett EMS to interview Ms. Howe. As part of his investigation, he took photos of bruising on her arms and legs and a small laceration on her ear. (Testimony of Agent Rabbitt; Testimony of Ms. Howe; Exhibit P-5).

62. Ms. Howe testified that, although she understood that Respondent was a physician and the infant in question was his patient, she believed that she was in charge of the child's care once she arrived at the scene. She believed that while she was required to take directions from the Puckett EMS medical director, she is only allowed to do what other physicians say if they give her a written order. She says the protocol is "a little bit of a sketchy area." She insisted that she does not have to take orders from "some random doctor." (Testimony of Ms. Howe).

63. According to Ga. Comp. R. & Regs. 511-9-2-.07(1)(i), "[c]ontrol of patient care at the scene of an emergency shall be the responsibility of the individual in attendance most appropriately trained and knowledgeable in providing prehospital emergency care and transportation." When a physician-patient relationship has been established "the Medic must follow the medical direction of that physician." A physician-patient relationship is established when "[a] physician is on the scene and demonstrates a willingness to assume responsibility for patient management or purports to be the patient's personal physician and the Medic takes reasonable steps to immediately verify the medical credentials of the physician." Id. 511-9-2-.07(1)(i)1. and 2.

II. Conclusions of Law

1. The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2. Pursuant to O.C.G.A. 43-34-6(a), Petitioner has the "powers, duties, and functions of professional licensing boards as provided in Chapter 1 of [O.C.G.A. Title 43]."

3. Professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has:

> [e]ngaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public that materially affects the fitness of the licensee . . . to practice a business or profession licensed under this title or is of a nature likely to jeopardize the interest of the public; such conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee . . . has committed any act or omission which is indicative of bad moral character or untrustworthiness. Such conduct or practice shall also include any departure from, or the failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title.

O.C.G.A. § 43-1-19(a)(6).

4. Similarly, under Georgia Code Section 43-34-8(a)(7), the Board has the authority to discipline a physician upon a finding by the Board that the licensee has:

> [e]ngaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimal standards of acceptable and prevailing medical practice or by rule of the board.

O.C.G.A. § 43-34-8(a)(7).

5. Ga. Comp. R. & Regs. 360-3-.02 authorizes the Board to take disciplinary action against a licensee for unprofessional conduct, which is defined as, among other things, as:

> (16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.

> (18) Any other practice determined to be below the minimal standards of acceptable and prevailing practice.

6. Additionally, professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has:

> "[v]iolated a statute, law, or any rule or regulation of this state, any other state, the professional licensing board regulating the business or profession licensed under this title, the United States, or any other lawful authority without regard to whether the violation is criminally punishable when such statute, law, or rule or regulation relates to or in part regulates the practice of a business or profession licensed under this title and when the licensee or applicant knows or should know that such action violates such statute, law, or rule."

O.C.G.A. § 43-1-19(a)(8). See also O.C.G.A. 43-34-8(a)(10) and Ga. Comp. R. & Regs. 360-3-.03.

7. Pursuant to Georgia Code Sections 43-1-19(d) and Ga. Comp. R. & Regs. 360-3-.01, Petitioner is authorized to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician or physician assistant for all the grounds set forth in O.C.G.A. § 43-34-8, and may impose a fine not to exceed $500 for each violation of a law, rule, or regulation relating to the licensed business or profession; or impose on a licensee fees or charges in an amount necessary to reimburse the professional licensing board for the administrative and legal costs incurred by the board in conducting an investigative or disciplinary proceeding.

8. Additionally, pursuant to Georgia Code Section 43-34-8(b)(1), Petitioner may take one or more of the following actions when the Board finds that a person is unqualified to be granted a license or that a licensee should be disciplined:

> (A) Refuse to grant a license, certificate, or permit to an applicant;
> (B) Place the licensee, certificate holder, or permit holder on probation for a definite or indefinite period with terms and conditions;
> (C) Administer a public or private reprimand, provided that a private reprimand shall not be disclosed to any person except the licensee, certificate holder, or permit holder;
> (D) Suspend any license, certificate, or permit for a definite or indefinite period;
> (E) Limit or restrict any license, certificate, or permit;
> (F) Revoke any license, certificate, or permit;

(G) Impose a fine not to exceed $3,000 for each violation of a law, rule, or regulation relating to the licensee, certificate holder, permit holder, or applicant;
(H) Impose a fine in a reasonable amount to reimburse the bord for the administrative costs;
(I) Require passage of a board approved minimum competency examination;
(J) Require board approved medical education;
(K) Condition the penalty, or withhold formal disposition, which shall be kept confidential, unless there is a public order upon the applicant, licensee, certificate holder, or permit holder's submission to the care, counseling, or treatment by physicians or other professional persons, which may be provided pursuant to Code Section 43-34-5.1, and the completion of such care, counseling, or treatment, as directed by the board; or
(L) Require a board approved mental and physical evaluation of all licensees, certificate holders, or permit holders.

9. Under Georgia law, a doctor-patient relationship is formed "where the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient." *Tomeh v. Bohannon*, 329 Ga. App. 596, 599 (Ga. Ct. App. 2014) (quoting *Anderson v. Houser*, 240 Ga. App. 613, 615 (Ga. Ct. App. 1999)). In *Tomeh*, the Court held that "[a] doctor who is merely on call, but who renders no treatment nor care to a patient does not have a doctor-patient relationship." *Id.* at 600. And while in *Tomeh* the physician "did not even meet" the patient in question, the Court is not convinced that Respondent consented to a doctor-patient relationship with S.C. simply by walking into the patient exam room and initiating a conversation with Ms. C[redacted]. Rather, the Court considers the fact that Respondent clearly communicated to Ms. C[redacted] that he would not be examining S.C. that day to show that he did not form a physician-patient relationship with her.

10. To be clear, the undersigned does not intend to condone Respondent's behavior towards Ms. C[redacted]. However, because the Matters Asserted filed by the Board did not contain any allegations regarding how Respondent spoke to her that day, the Court may not consider whether that behavior would justify sanctions against him. *See* O.C.G.A. § 50-13-13(a)(2)(D) ("The notice shall include. . . [a] short and plain statement of the matters asserted.").

11. The Court further concludes that the Board did not prove, by a preponderance of the evidence, that Respondent purposefully hit Ms. Summers car with his shopping cart on December 5, 2019. Ms.

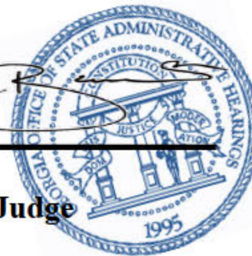
Summers was a credible witness, but she admitted that she never saw Respondent push his cart into her car. She even stated that, when she called the police, she was still not exactly sure what had happened. Meanwhile, Respondent provided an explanation for why he pushed his cart away from him that was at least plausible.

12. The Board similarly did not prove that it is more likely than not that Respondent "tackled and struck" Ms. Howe on July 21, 2022. (*See* Notice of Hearing). The Court takes Ms. Howe's accusations very seriously. However, after thoroughly reviewing both her and Respondent's explanation of events, the undersigned cannot conclude that it is more likely than not that they are true. Ms. Howe only said that she and Respondent "ended up fighting to the floor" and did not clearly state that Respondent attacked her. Respondent's explanation, in which Ms. Howe started towards him and he defended himself, is plausible.
13. The three events described at the hearing suggest that Respondent has a concerning pattern of sometimes unnecessarily escalating tensions, and he very well may benefit from the anger management courses the Board recommends. However, the Board was required to prove each of its specific accusations of Respondent by a preponderance of the evidence, and it did not do so here.

III. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Board's decision to sanction Respondent's medical license is **REVERSED**.

SO ORDERED, this 12th day of May, 2023.



Shakara M. Barnes
Administrative Law Judge