November 2022 Public Board Actions List

Georgia Composite Medical Board
Attn: **Ms. Latisha Bias**, Public Records Unit
2 Peachtree Street, N.W., 6th Floor
Atlanta, Georgia 30303-3465
PH: (404) 657-3194
FX: (404) 463-2539
Email: latisha.bias@dch.ga.gov

The Board issued **five** public orders in **November 2022**. To view each Board order, click on the licensee's name below.

1. **Vinson Disanto, DO**
51926
Physician
Final Decision

2. **Frederick Fritzsche, Jr., MD**
48045
Physician
Public Consent Order

3. **Daniel Golightly, MD**
12470
Physician
Order of Completion

4. **Andrew Jimerson, II, MD**
57378
Physician
Final Decision

5. **Jennifer Miller Rafus**
374
Acupuncturist
Public Consent Agreement for Reinstatement

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:	)	
	)	OSAH Docket No.: 2303010
VINSON DISANTO, DO,	)	2303010-OSAH-GCMB-PHY-222-Barnes
License No. 51926,	)	
Respondent.	)	BOARD DOCKET NO:
	)	

FINAL DECISION

An Initial Decision was issued by the Office of State Administrative Hearings in the above matter on October 28, 2022. Respondent was served with the Initial Decision on October 28, 2022. In the absence of an application to the agency for review of said Initial Decision, or an order by the Board to review said Initial Decision on its own motion, said Initial Decision becomes the Final Decision of the Board by operation of law, pursuant to O.C.G.A. § 50-13-17(a).

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

DECISION AND ORDER

The recommendation of the Administrative Law Judge that Respondent's license to practice medicine in the State of Georgia be placed on **PROBATION**, with the terms as set forth in the Initial Decision, is adopted and incorporated by reference and, having become final on

November 28, 2022, is hereby made the Final Decision of the Board, effective November 28, 2022.

SO ORDERED, this 29 day of November, 2022.

GEORGIA COMPOSITE MEDICAL BOARD

MATTHEW W. NORMAN, M.D.
Chairperson

DANIEL DORSEY
Executive Director

(BOARD SEAL)

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, **Petitioner,**	**Docket No.: 2303010** **2303010-OSAH-GCMB-PHY-222-Barnes**
v.	**Agency Reference No.: 51926**
VINSON DISANTO, DO, **Respondent.**	

INITIAL DECISION

I. Introduction

Petitioner, the Georgia Composite Medical Board ("Board") brought this action seeking to revoke Respondent's license to practice medicine in Georgia. The Board also requested the imposition of costs it incurred through the investigation and administrative action. The evidentiary hearing took place before the undersigned administrative law judge. The Board was represented by Thomas McNulty, Esq., Assistant Attorney General. Respondent appeared through pre-approved video conference and represented himself at the hearing. After careful consideration of the evidence and arguments presented, and for the reasons stated below, the Board's decision to sanction Respondent's license is **AFFIRMED and MODIFIED**.

II. Findings of Fact

1. Respondent is licensed to practice medicine in the State of Georgia and was licensed at all times relevant to this proceeding. Respondent testified that he has been in practice since 1986 and is licensed in approximately 37 states.

2. On or about October 2, 2019, the Medical Licensure Commission of Alabama (the "Alabama Board") issued a Final Order (the "Alabama Final Order") against Respondent

in which the Alabama Board revoked Respondent's Alabama license to practice medicine (Case No. 19-140) after finding the following:

a) Respondent was "unable to practice medicine or osteopathy with reasonable skill and safety to patients by reason of a demonstrated lack of medical knowledge or clinical competency as set out in § 34-24-360(20)(a) Ala. Code (1975);" and

b) Respondent had "received disciplinary action in another state against his license to practice medicine or osteopathy based upon acts by the licensee similar to acts described in § 34-24-360.

3. On or about March 1,2022, the Alabama Board granted Respondent's request for reinstatement of his license to practice medicine or osteopathy in Alabama, pursuant to the following terms of probation, as specified in the Alabama Final Order:

a) Before entering into the practice of medicine or osteopathy in Alabama, Respondent shall submit a reasonably detailed practice plan to, and shall receive approval of the same from, the Commission. Respondent's practice plan shall incorporate and comply with all provisions of this Order.

b) Respondent shall not be permitted to practice medicine or osteopathy in Alabama via telemedicine.

c) Respondent shall not be permitted to practice in an emergency room setting, nor provide emergent/urgent/acute care in Alabama.

d) Respondent shall establish a physical location in Alabama at which to see and treat Alabama patients.

e) During the first six months of Respondent's practice in Alabama, or until Respondent shall have seen at least 30 individual patients in Alabama, which later occurs, Respondent's practice in Alabama shall be directly and personally supervised on-site by another Alabama-licensed physician.

f) Each calendar quarter, no fewer than five charts selected by a Commission investigator will be reviewed by a reviewer of Commission's choosing, at Respondent's expense.

g) Within six months of the date of this Order Respondent shall complete no fewer than 50 hours of AAFP or AMA-PRA Category 1 credit from high quality sources such as the AAFP, Core Content Review of Family Medicine, or similar offerings. Continuing medical education completed before the date of this Order do not count toward this requirement.

4. The Georgia Composite Medical Board is authorized to discipline Respondent's medical license based on disciplinary action taken by another lawful licensing authority.

III. Conclusions of Law

1. Because this case concerns the proposed revocation of Petitioner's medical license, the Board bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21.

2. The Board seeks to sanction Respondent's medical license pursuant to various statutes and rules, to include: O.C.G.A. § 43-34-1, *et seq.*; the rules of the Georgia Composite Medical Board, found at Ga. Comp. R. & Regs., Ch. 360; and the general statutory provisions related to professional licensing boards, O.C.G.A. § 43-1-1, *et seq.*

3. Pursuant to O.C.G.A. § 43-34-6(a), the Board has the powers, duties, and functions of professional licensing boards as provided in Chapter 1 of Title 43.

4. O.C.G.A. § 43-1-19(a) provides that a professional licensing board shall have the authority to revoke the license of a person licensed by that board or to discipline a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:

> (5) Had his or her license to practice a business or profession license under this title revoked, suspended, or annulled by any lawful licensing authority other than the board; had other disciplinary action taken against him or her by any such lawful licensing authority other than the board; was denied a license by any such lawful licensing authority other than the board, pursuant to disciplinary proceedings; or was refused the renewal of a license by any such lawful licensing authority other than the board, pursuant to disciplinary proceedings;
>
> ...
>
> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness. Unprofessional conduct shall also include any departure from, or failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title;
>
> ...
>
> (8) Violated 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; or violated a lawful order of the board;

5. O.C.G.A. § 43-1-19(d) provides that when a professional licensing board finds that any person should be disciplined pursuant to subsection (a) of § 43-1-19 or the laws, rules, or

regulations relating to the business or profession licensed by the board, the board may take any one or more of the following actions:

> (1) Refuse to grant or renew a license to an applicant;
>
> (2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;
>
> (3) Suspend any license for a definite period or for an indefinite period in connection with any condition which may be attached to the restoration of said license;
>
> (4) Limit or restrict any license as the board deems necessary for the protection of the public;
>
> (5) Revoke any license;
>
> (6) Condition the penalty upon, or withhold formal disposition pending, the applicant's or licensee's submission to such care, counseling, or treatment as the board may direct;
>
> (7) Impose a fine not to exceed $500.00 for each violation of a law, rule, or regulation relating to the licensed business or profession; or
>
> (8) Impose on a licensee or applicant 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.

In addition, O.C.G.A. § 43-1-19(e) provides that, in addition to and in conjunction with the actions described in subsection (d) of this Code section, a professional licensing board may make a finding adverse to the licensee or applicant but withhold imposition of judgment and penalty; or it may impose the judgment and penalty but suspend enforcement thereof and place the licensee on

probation, which probation may be vacated upon noncompliance with such reasonable terms as the board may impose.

6. Furthermore, O.C.G.A. § 43-34-8(b)(1) provides that when the board finds that any person is unqualified to be granted a license, certificate, or permit or finds that any person should be disciplined pursuant to O.C.G.A. § 43-34-8(a), the board may take any one or more of the following actions:

(A) Refuse 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 $3,000.00 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 board for 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.

In addition, O.C.G.A. § 43-34-8(b)(2), provides that, in addition to and in conjunction with the actions enumerated pursuant to paragraph (1) of this Code section, the board may make a finding adverse to the licensee, certificate holder, permit holder, or applicant but withhold imposition of judgment and penalty; or it may impose the judgment and penalty but suspend enforcement thereof and place the licensee, certificate holder, permit holder, or applicant on probation, which may be vacated upon noncompliance with such reasonable terms as the board may impose.

7. Ga. Comp. R. & Regs. r. 360-3-.01 provides that:

The Georgia Composite Medical Board ("Board") 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 to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician pursuant to O.C.G.A. § 43-34-8. In addition, the Board is authorized to terminate the approval of a physician's assistant and to revoke the license of a physician's assistant pursuant to O.C.G.A. § 43-34-107.

8. Ga. Comp. R. & Regs. r. 360-3-.03 states, in part:

The Georgia Composite Medical Board is authorized to take disciplinary action for violations of laws and rules and regulations which relate to or in part regulate the practice of medicine. These laws, rules and regulations include, but are not limited to, the following:

(1) The Georgia Medical Practice Act (O.C.G.A. T. 43, Ch. 34);

*****

(6) The Rules of the Georgia Composite Medical Board, Ch. 360, Rules and Regulations of the State of Georgia;

9. The Court concludes that the Board has met its burden of showing by a preponderance of the evidence that the aforementioned rules, statutes, and provisions authorize the Board to sanction Respondent's medical license under these facts. However, the Court concludes that a revocation is not the appropriate sanction in this case.

IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Board's decision to sanction Respondent's medical license is **AFFIRMED but MODIFIED**. Respondent's Georgia medical license shall not be revoked. Rather, the Board shall sanction Respondent's medical license in a manner that mirrors the terms—including the probationary period—set forth in the Alabama Final Order:

a) Before entering into the practice of medicine or osteopathy in Georgia, Respondent shall submit a reasonably detailed practice plan to, and shall receive approval of the same from, the Commission.

b) Respondent shall not be permitted to practice medicine or osteopathy in Georgia via telemedicine.

c) Respondent shall not be permitted to practice in an emergency room setting, nor provide emergent/urgent/acute care in Georgia.

d) Respondent shall establish a physical location in Georgia at which to see and treat Georgia patients.

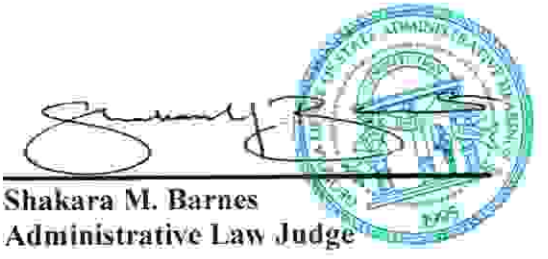
e) During the first six months of Respondent's practice in Georgia—to begin on the date of this Initial Decision—or until Respondent shall have seen at least 30 individual patients in Georgia, whichever later occurs. Respondent's practice in Georgia shall be directly and personally supervised on-site by another Georgia-licensed physician.

f) Each calendar quarter, no fewer than five charts (prepared by the Respondent) selected by a Board investigator will be reviewed by a reviewer of the Board's choosing, at Respondent's expense.

g) Within six months of the date of this Initial Decision, Respondent shall complete no fewer than 50 hours of continuing medical education from high quality, Board-accepted sources.

Additionally, Respondent shall pay to the Board the legal costs associated with the administrative proceeding, including but not limited to, investigative costs and the costs recorded by the Court.

SO ORDERED, this 28th day of October, 2022.



Shakara M. Barnes
Administrative Law Judge

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

IN THE MATTER OF:	*		GEORGIA COMPOSITE MEDICAL BOARD
	*		
FREDERICK FRITZSCHE, JR., M.D.,	*		NOV 0 3 2022
License No. 48045,	*	DOCKET NO.:	
	*		DOCKET NUMBER: 20230029
Respondent.	*		

PUBLIC CONSENT ORDER

By agreement of the Georgia Composite Medical Board ("Board") and FREDERICK FRITZSCHE, JR., M.D. ("Respondent"), the following disposition of this disciplinary matter is entered pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A § 50-13-13 as amended.

FINDINGS OF FACT

1.

Respondent is licensed to practice medicine in the State of Georgia and was so licensed at all times relevant to the facts stated herein.

2.

On or about March 10, 2020, the Board received a complaint regarding Respondent's prescribing of controlled substances. Specifically, the concern expressed was that Respondent was writing prescriptions improperly and for non-pain related symptoms.

3.

Respondent's medical care of multiple patients was evaluated by a Board-appointed peer reviewer who concluded that Respondent's diagnosis, treatment and/or records departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

- Respondent failed to document medical histories, vital signs and physical exams.
- Respondent used opioids to manage cough symptoms for upper respiratory infections, sinus infections and COPD exacerbations.

4.

Respondent also had the medical care of the aforementioned patients evaluated by independent physician experts. Although, Respondent's experts found Respondent's documentation of patients' visit to need more detail, they only found one patient encounter to fall below the minimum standard of care. There was no injury or damage to the patient.

5.

Respondent neither admits nor denies the above findings of fact but waives further findings and agrees to the entry of this Order in order to resolve the pending allegations.

CONCLUSIONS OF LAW

Respondent's conduct constitutes sufficient grounds for the Board to exercise disciplinary authority under O.C.G.A. Chs. 1 and 34, T. 43, as amended, and the Rules of the Georgia Composite Medical Board. Respondent waives any further conclusions of law with respect to the above-styled matter.

ORDER

The Board, having considered the particular facts and circumstances of this case, hereby ordered, and Respondent hereby agrees to the following:

1.

Within **six (6) months** of the effective date of this Consent Order, Respondent shall

submit to the Georgia Board a fine of five thousand dollars ($5,000.00) to be paid in full by cashier's check or money order made payable to the Georgia Composite Medical Board. Said fine shall be sent to the Georgia Composite Medical Board, located at 2 Peachtree Street, NW, 6th Floor, Atlanta, GA 30303, to the attention of the Executive Director. Failure to pay the entire amount within six (6) months of the effective date of this Consent Order shall be considered a violation of this Consent Order and shall result in further sanctioning of Respondent's license, upon substantiation thereof.

2.

Within **six (6) months** of the effective date of this Consent Order, Respondent shall provide to the Board evidence that he has completed the following continuing medical education (CME):

A mini-residency program entitled "Appropriate Prescribing of Controlled Substances" sponsored by the Mercer University Southern School of Pharmacy, or a similar course pre-approved by the Board; and said (CME) shall be in addition to the CME required license renewal. Failure to provide written evidence of successful completion of the CME within six (6) months of the effective date of this Consent Order shall be considered a violation of this Consent Order and shall result in further sanctioning of Respondent's license, upon substantiation thereof.

3.

This Consent Order and the dissemination thereof shall constitute a public reprimand to the Respondent for his conduct.

4.

Respondent understands that pursuant to O.C.G.A. Title 43, Chapter 34A, the contents of this Consent Order shall be placed on Respondent's Physician Profile. Furthermore, by executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician's Profile reflecting this Consent Order.

5.

The effective date of this Consent Order is the date the Consent Order is docketed. Respondent should receive a docketed copy of the Consent Order form the Board at the Respondent's address of record within ten (10) business days of the docket date. If Respondent has not received a docketed copy of the Consent Order, it is Respondent's responsibility to obtain a docketed copy of the Consent Order from the Board. Respondent must comply with the terms and conditions of the Consent Order beginning on the effective date.

6.

Approval of this Order by the Board shall in no way be construed as condoning Respondent's conduct and, except as provided herein, shall not be construed as a waiver of any of the lawful rights of the Board.

7.

Respondent acknowledges that he has read and understands the contents of this Consent Order. Respondent understands that he has the right to a hearing in this matter, and Respondent freely, knowingly and voluntarily waives such right by entering into this Consent Order. Respondent further understands and agrees that the Board shall have the authority to review the investigative file and all relevant evidence in considering this Consent Order. Respondent further understands that this Consent Order, once approved and docketed, shall constitute a public record and may be disseminated as such. However, if the Consent Order is not approved, it shall

record and may be disseminated as such. However, if the Consent Order is not approved, it shall not constitute an admission against interest in the proceeding, or prejudice the right of the Board to adjudicate the matter. Respondent understands that this Consent Order will not become effective until approved and docketed by the Georgia Composite Medical Board. Respondent consents to the terms contained herein.

Approved, this 3rd day of August, 2022.

GEORGIA COMPOSITE MEDICAL BOARD

BY: _____
MATTHEW W. NORMAN, M.D.
Chairperson

ATTEST: _____
DANIEL R. DORSEY
Executive Director

CONSENTED TO: _____
FREDERICK FRITZSCHE, M.D.
Respondent

AS TO THE SIGNATURE OF FREDERICK FRITZSCHE, M.D.:
Sworn to and subscribed before me this, 27 day of November, 2022.

_____
NOTARY PUBLIC
My Commission Expires:

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

IN THE MATTER OF:	*		
	*		
DANIEL GOLIGHTLY, M.D.,	*	DOCKET NO.:	
License No. 12470,	*		
	*		
Respondent.	*		

ORDER OF COMPLETION

WHEREAS, on or about April 13, 2022, the Georgia Composite Medical Board (hereinafter "Board") and DANIEL GOLIGHTLY, M.D., (hereinafter "Respondent") entered into a Public Consent Order (Docket Number 20220075), requiring the completion of continuing medical education course entitled "Appropriate Prescribing of Controlled Substances and a Board approved course on medical record documentation.

WHEREAS, on or about September 7, 2022, Respondent petitioned for an Order of Completion.

WHEREAS, upon review, the Board has determined that Respondent has complied with the terms of the Consent Order to the satisfaction of the Board.

THEREFORE, the Board hereby enters this Order of Completion to indicate that Respondent has successfully completed the terms of the Public Consent Order, Docket Number 20220075. Respondent's license is in good standing.

This 17th day of November, 2022.

GEORGIA COMPOSITE MEDICAL BOARD

BY: _____
MATTHEW W. NORMAN, M.D.
Chairperson

ATTEST: _____
DANIEL R. DORSEY
Executive Director

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

IN THE MATTER OF:	*		GEORGIA COMPOSITE MEDICAL BOARD
DANIEL GOLIGHTLY, M.D. License No. 124 70.	*	DOCKET NO.:	APR 13 2022
Respondent.	*		DOCKET NUMBER: 2022-0075

PUBLIC CONSENT ORDER

By agreement of the Georgia Composite Medical Board ("Board") and DANIEL GOLIGHTLY, M.D. ("Respondent"), the following disposition of this disciplinary matter is entered pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A § 50-13-13 as amended.

FINDINGS OF FACT

1.

Respondent is licensed to practice medicine in the State of Georgia and was so licensed at all times relevant to the facts stated herein.

2.

Patient C.D.

On or about October 20, 2018, the Board received a complaint regarding Respondent's prescribing of controlled substances. Specifically, the concern expressed was that Respondent continued to prescribe patient "C.D." Xanax (alprazolam) despite knowledge that the patient had a history of prescription drug abuse. From in or about September of 2015, through January of 2019, patient C.D. was treated by Respondent opiate dependency and anxiety disorder. Respondent's treatment included, inter alia, prescribing Suboxone 8mg or Alprazolam 1mg thirty (30) times from on or about February 20, 2017 to January 14, 2019. Respondent's medical care

of C.D. was evaluated by a Board-approved peer reviewer who concluded that Respondent's diagnosis, treatment and/or records departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

- Failure to document a comprehensive initial psychiatric assessment prior to initiating and maintaining treatment;
- No documented diagnosis that correlates with the prescription of Xanax;
- Continued prescription of buprenorphine with benzodiazepines without a documented plan to reduce the dose and/or frequency of the benzodiazepine, or an attempt to use non-addictive medications first;
- Failure to obtain a corroborative history from a friend or family member to confirm that the patient is using medications appropriately.

3.

Patient J.N.

Patient J.N. was seen by Respondent between 2014 and 2019 for anxiety disorder, depression, and pain. Respondent's treatment included, inter alia, the use of opioid medications to high doses of benzodiazepines, along with other psychotropic medications. Respondent's medical care of J.N. was evaluated by a Board-approved peer reviewer who concluded that treatment departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

- Little, if any, mention of recommendations for psychotherapy for treatment of anxiety;
- Regarding the choice, dosing and combination of medications, the treatment does not meet minimal standards of care;
- No records of Respondent attempting to wean or reduce or minimize the use of benzodiazepines;
- Prescription of 6mg of Xanax a day, with concurrent opioid medication, is an unusually high dose and beyond the maximum dosage for anxiety disorders;
- Failure to routinely and regularly check urine drug screens and/or review outside records to corroborate patient's report of back pain.

4.

Patient H.K.

From in or about June of 2017, through August of 2018, patient H.K. was treated by Respondent for opiate dependency, anxiety disorder, and insomnia. Respondent's treatment included, inter alia, prescribing buprenorphine-naloxone and benzodiazepines. Respondent's medical care of H.K. was evaluated by a Board-approved peer reviewer who concluded that Respondent's diagnosis, treatment and/or records departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

- The dosage and continued prescribing of scheduled/controlled medications to treat addiction, anxiety, and insomnia after inconsistent confirmatory urine drug testing;
- Continued prescription of Suboxone after confirmatory urine drug screen results showed a relapse of heroin, morphine, and hydromorphone without a documented discussion with the patient regarding the drug screen results;
- Increased frequency of Xanax after a documented failure by patient to follow the treatment plan;
- Prescription of a benzodiazepine with Suboxone without documented attempts to minimize usage or outline a plan for cessation, or attempt other non-additive medications first;
- Failure to address concurrent use of oxycodone interspersed with Suboxone use with patient.

5.

Respondent admits the above findings of fact and waives further findings and agrees to the entry of this Order in order to resolve the pending allegations.

CONCLUSIONS OF LAW

Respondent's conduct constitutes sufficient grounds for the Board to exercise disciplinary authority under O.C.G.A. Chs. 1 and 34, T. 43, as amended, and the Rules of the Georgia Composite Medical Board. Respondent waives any further conclusions of law with respect to the above-styled matter.

ORDER

The Board, having considered the particular facts and circumstances of this case, hereby ordered, and Respondent hereby agrees to the following:

1.

Within six (6) months of the effective date of this Consent Order, Respondent shall provide to the Board evidence that he has completed the following continuing medical education (CME):

a. A mini-residency program entitled "Appropriate Prescribing of Controlled Substances" sponsored by the Mercer University Southern School of Pharmacy, or a similar course pre-approved by the Board; and said (CME) shall be in addition to the CME required license renewal. Failure to provide written evidence of successful completion of the CME within six (6) months of the effective date of this Consent Order shall be considered a violation of this Consent Order and shall result in further sanctioning of Respondent's license, upon substantiation thereof.

b. A Board approved course on medical record documentation. This requirement shall be deemed satisfied upon the Board's receipt of evidence of successful completion of the course; and said (CME) shall be in addition to the CME required license renewal. Failure to provide written evidence of successful completion of the CME within six (6) months of the effective date of this Consent Order shall be considered a violation of this Consent Order and shall result in further sanctioning of Respondent's license, upon substantiation thereof.

2.

This Consent Order and the dissemination thereof shall constitute a public reprimand to the Respondent for his conduct.

3.

Respondent understands that pursuant to O.C.G.A. Title 43, Chapter 34A, the contents of this Consent Order shall be placed on Respondent's Physician Profile. Furthermore, by executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician's Profile reflecting this Consent Order.

4.

Approval of this Order by the Board shall in no way be construed as condoning Respondent's conduct and, except as provided herein, shall not be construed as a waiver of any of the lawful rights of the Board.

5.

Respondent acknowledges that he has read and understands the contents of this Consent Order. Respondent understands that he has the right to a hearing in this matter, and Respondent freely, knowingly and voluntarily waives such right by entering into this Consent Order. Respondent further understands and agrees that the Board shall have the authority to review the investigative file and all relevant evidence in considering this Consent Order. Respondent further understands that this Consent Order, once approved and docketed, shall constitute a public record and may be disseminated as such. However, if the Consent Order is not approved, it shall not constitute an admission against interest in the proceeding, or prejudice the right of the Board to adjudicate the matter. Respondent understands that this Consent Order will not become effective until approved and docketed by the Georgia Composite Medical Board. Respondent consents to the terms contained herein.

(signatures on following page)

Approved, this 13th day of Apr. 1, 2022.

GEORGIA COMPOSITE MEDICAL BOARD

BY: _____
DESPINA DALTON, M.D.
Chairperson

ATTEST: _____
DANIEL R. DORSEY
Executive Director

CONSENTED TO: _____, M.D.
DANIEL GOLIGHTLY, M.D.
Respondent

AS TO THE SIGNATURE OF DANIEL GOLIGHTLY, M.D.:
Sworn to and subscribed before me this 28 day of MARCH, 2022.

_____
NOTARY PUBLIC
My Commission Expires:

ARLENE J KISH
Notary Public - State of Georgia
Fulton County
My Commission Expires Jan 14, 2024

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:	)	
	)	OSAH Docket No.: 2223751
ANDREW JIMERSON II, MD,	)	2223751-OSAH-GCMB-PHY-67-Barnes
License No. 57378,	)	
Respondent.	)	BOARD DOCKET NO:
	)	

FINAL DECISION

An Initial Decision was issued by the Office of State Administrative Hearings in the above matter on October 24, 2022. Attorney for the Respondent was served with the Initial Decision on October 24, 2022. In the absence of an application to the agency for review of said Initial Decision, or an order by the Board to review said Initial Decision on its own motion, said Initial Decision becomes the Final Decision of the Board by operation of law, pursuant to O.C.G.A. § 50-13-17(a).

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are adopted and incorporated by reference herein.

DECISION AND ORDER

The recommendation of the Administrative Law Judge that NO DISCIPLINARY ACTION be taken against Respondent and that NO SANCTIONS be imposed against his medical license, is adopted and incorporated by reference and, having become final on

November 23, 2022, is hereby made the Final Decision of the Board, effective November 23, 2022.

SO ORDERED, this 29 day of November, 2022.

GEORGIA COMPOSITE MEDICAL BOARD

MATTHEW W. NORMAN, M.D.
Chairperson

DANIEL DORSEY
Executive Director

(BOARD SEAL)

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, **Petitioner,** **v.** **ANDREW JIMERSON II M.D.,** **Respondent.**	**Docket No. 2223751** **2223751-OSAH-GCMB-PHY-67-Barnes**[1] **Agency Reference No. 57378**

INITIAL DECISION

The Georgia Composite Medical Board ("Petitioner" or "Board") initiated this matter for the purpose of pursuing disciplinary action against Respondent Dr. Andrew Jimerson, II's license to practice as a physician. Specifically, Petitioner seeks to have Respondent's license placed on probation during which time at least ten patients treated by Respondent would be proctored by a board certified plastic surgery, that he pay a fine of $10,000, and that he be required to complete 20 hours of continuing medical education in the area of liposuction. The hearing was conducted on August 23-24, 2022, at the Office of State Administrative Hearings.[2] The Board was represented by Senior Assistant Attorney General Sandra J. Bailey, esq., and the Respondent was represented by Robert G. Rubin, Esq. and Harrison Kohler, Esq.. After careful consideration of the evidence presented, the Board's request to impose sanctions against Respondent's license to practice as a physician is **DENIED.**

[1] Judge Kennedy sat in for Judge Barnes.
[2] The time to issue a decision was extended to October 21, 2022, by order of the Court pursuant to Ga. Comp. R. &. Regs. 616-1-2-.27(2).

I. Findings of Fact

1.

Respondent holds a license to practice as a physician in the State of Georgia and he held such license at all times relevant to the issues presented for hearing. (Exhibit P-1).

2.

Respondent earned his medical degree from Case Western Reserve University in 2000. He completed his graduate medical education from 2000 to 2006 at Ohio State Plastic Surgery. He is board certified in plastic surgery. He has 22 years of experience as a plastic surgeon and has performed 6,000 to 7,000 surgeries. He holds memberships in The American Society for Aesthetic Plastic Surgery, The American Society of Plastic Surgery, Inc., American Society of Plastic Surgeons, and Georgia Society of Plastic Surgery. (Testimony of Respondent; Exhibit P-1).

3.

Respondent's license was issued on February 2, 2006. It is currently Active. It is set to expire on March 31, 2023. His designation is MD. His specialty is listed as Plastic Surgery. (Exhibit P-1).

4.

During the time at issue in this matter, Respondent's practice was called Advanced Plastic Surgery Solutions and was located at 6620 McGinnis Ferry Road, Johns Creek, Georgia 30097. He performed outpatient procedures at his onsite surgical center called Solutions Surgical Center, and he had hospital privileges at Emory Johns Creek Hospital and Northside Hospital Forsyth. Currently, he has hospital privileges at Northside Hospital Forsyth and Northside Atlanta. Respondent no longer has privileges at Emory Johns Creek Hospital because he chose to "resign" from that facility. (Testimony of Respondent; Exhibits P-1, P-4).

5.

In 2007, Respondent performed his first surgery involving fat grafting to the buttocks, which is also known as a Brazilian Butt Lift (BBL). At the time, it was a fairly new procedure in the field of plastic surgery. (Testimony of Respondent)

6.

In 2018, Respondent had a second plastic surgeon, Dr. Gordon, who worked at Advanced Plastic Surgery. At that time, along with Dr. Gordon, Advanced Plastic Surgery completed approximately 600 to 800 surgeries annually; 98% of which involved BBL. (Testimony of Respondent).

7.

In 2018, Respondent's medical practice attracted the attention of Emory Johns Creek Hospital who notified Petitioner and the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) of Respondent's patients who were diagnosed with postoperative anemia and who received blood transfusions within days after having undergone plastic surgery at Respondent's outpatient surgical center. (Testimony of Dr. Carmen M. Kavali; Testimony of Dr. Monte Jay Goldstein; Testimony of Respondent)

8.

Carmen M. Kavali, M.D., is a board-certified plastic surgeon licensed to practice in Georgia and North Carolina. She earned her medical degree from Mercer University in 1996. Her post graduate medical education included serving as a Plastic Surgery Fellow from 2000 to 2002 at Wayne State University in Detroit, Michigan. She has been licensed to practice in Georgia since 2002, and she has been Board-certified in plastic surgery since 2003. She is a member of numerous professional affiliations, has received various awards and honors, has been published on a variety of topics, and has conducted clinical research. She has hospital admission privileges at Northside Hospital of

Atlanta and Perimeter Surgery Center. (Testimony of Dr. Carmen Kavali; Exhibit P-3).

9.

Petitioner provided Dr. Kavali records related to certain of Respondent's patients who underwent surgeries between March 2017 and October 2018 for the purpose of having her conduct a peer review. From October 27 to November 4, 2019, and from January 3 to 4, 2020, Dr. Kavali spent 21 hours reviewing the medical records of several of Respondent's patients from 2017-2018 who presented at Emory Johns Creek Hospital within 1-week of undergoing outpatient elective surgery and who were subsequently provided blood transfusions after being diagnosed with postoperative anemia. The cost charged to Petitioner for this review was $100 per hour for a total of $2,100. (Testimony of Dr. Kavali; Exhibit P-2).

10.

Based on her review of the records, Dr. Kavali opined that Respondent's treatment and/or diagnosis of the patients at issue departed from or failed to conform to minimum standards of acceptable and prevailing medical practice. However, Dr. Kavali did not identify with any specificity during her testimony how Respondent's practice or treatment of his patients departed from the minimum standard of acceptable and prevailing medical practice. Instead, she opined "there's something wrong, it's either the estimation is wrong, the procedure's wrong, I don't know because I'm not there, but the outcomes are wrong" and the estimation of blood loss "must be part of it." She further opined that "patient selection, the aggressiveness of the surgery, the length of surgery, the type of surgery, the estimation of blood loss, something in that mix was not right." (Testimony of Dr. Kavali).

11.

The complication that eight (8) of Respondent's patients experienced and that are at issue in this

matter was postoperative anemia. Anemia is low hemoglobin or low blood volume; those two things are correlated. Essentially, because red blood cells carry oxygen to all of a person's organs, it is important to always have a healthy number of red blood cells in our bodies at any given time. When a person suffers from acute postoperative anemia their body will attempt to compensate for the low hemoglobin by, among other things, increasing heart rate or increasing scavenging oxygen from the hemoglobin that is available. However, at some point a person's body can exceed those compensatory mechanisms and that can result in fatigue, syncope, kidney failure, and other symptoms up to death. (Testimony of Dr. Kavali)

12.

Anemia can be caused by a variety of factors, blood loss being one of them. Blood loss from liposuction should be minimal, especially if the super wet technique is used in high volume lipoplasty procedures even when general anesthetic is used, but that doesn't mean the blood loss is minimal in every case. For example, blood loss can be affected by how much epinephrine a doctor uses in their tumescent recipe, how long the doctor lets the tumescent sit before they start aspirating, and the total aspirate itself. (Testimony of Dr. Kavali)

13.

At the conclusion of surgery, a surgeon and the nurse anesthetist are expected to estimate blood loss. Dr. Kavali acknowledged that accurately estimating blood loss is difficult.[3] However, there are things a doctor can do to gauge what they are doing with their patient. For example, if the aspirate is buttery that indicates it has very little blood in it, if the aspirate is red it has some blood, and if the aspirate is burgundy it has a lot of blood. (Testimony of Dr. Kavali)

[3] Dr. Mendieta also testified that it can be difficult to estimate blood loss because even though the canister shows a certain amount of aspirate that aspirate includes water, blood, and fat. According to Dr. Mendieta, fat floats so that goes up and you have the fluid at the bottom, which allows you to know how much fluid there is in total but how much of that fluid is blood is where it becomes a guessing game. (Testimony of Dr. Mendieta).

14.

It is the responsibility of both the surgeon and the nurse anesthetist to estimate blood loss during a surgery, which is typically based on visualization when performing liposuction and also taking into consideration the amount of tumescent fluid injected prior to the surgery. The larger the amount of tumescent fluid that is injected prior to the surgery should result in a lower amount of blood that ends up in the canister. Even though both the surgeon and the nurse anesthetist estimate blood loss, it is not atypical for a nurse anesthetist to ask the surgeon what he/she estimated the blood loss to be and then writing that number down on the anesthesia records. (Testimony of Dr. Kavali)

15.

It is not uncommon for surgeons to have complications when performing surgeries. However, it is rare for a patient to need a blood transfusion following an out-patient surgery. The national average for this type of complication is approximately three (3) to (5) percent. For Respondent, during the time period at issue, it is known that he had eight (8) patients over nine (9) surgeries receive a blood transfusion.[4] Based on Respondent's estimation that his practice completed 600 to 800 surgeries, Respondent's complication rate was approximately 1 to 1.5%, which could be considered rare. (Testimony of Dr. Kavali; Testimony of Dr. Constantino Mendieta; Testimony of Respondent)

16.

Dr. Kavali testified that a single case of postoperative anemia would not be concerning but, in this matter, it is the hospitalizations and need for transfusions for multiple patients over a short time

[4] Patient Ali. M. had three surgeries, but only two fell within the time period at issue. The third surgery occurred in 2019. Patient J.L. had two surgeries but only one fell within the time period at issue. The second surgery occurred in 2019. (Joint Exhibit pp. 758-1676 and 2989-3627)

span that leads her to believe that Respondent failed to accurately assess and record estimated blood loss for his patients. Her opinion is based on the result – because eight (8) patients went to the emergency room and were diagnosed with postoperative anemia Respondent must have done something wrong in estimating blood loss. (Testimony of Dr. Kavali)

17.

According to Dr. Kavali, if she had one patient suffer from postoperative anemia she would review what she did and try to determine if there was something she may have overlooked or missed, but it would not necessarily raise an alarm. Dr. Kavali further testified that if she, or she believes any doctor, had two patients who were diagnosed with postoperative anemia, they would review their procedures and determine what they missed during surgery to correct the issue to not have any more patients experience postoperative anemia. Dr. Kavali's concern regarding Respondent is that he had eight (8) patients over a period of 19 months that were diagnosed with postoperative anemia, which she found to be disconcerting and a sign that Respondent must not have followed standard of care when performing plastic surgery. Dr. Kavali opined that Respondent did not safely execute surgeries in an out-patient surgical center because if he had then he would not have had several patients present to the emergency room immediately following surgery or within a week of surgery with acute postoperative anemia and that resulted in those patients receiving a blood transfusion. Specifically, Dr. Kavali testified that "when there are a multitude of cases with the same complication repeatedly there is a problem with the surgeon, the patient selection, the procedure, the execution of the procedure, there is a problem." So, her concern is that she believes Respondent must have grossly underestimated his patients' blood loss during surgery. Dr. Kavali testified that the estimated blood loss of some patients showing 100, 150 or 200 are not levels at which you would expect to see postoperative anemia. Thus, Dr. Kavali opined that Respondent

must have grossly misestimated the blood loss of his patients during surgery. (Testimony of Dr. Kavali)

Patient Ale.M.[5]

18.

Patient Ale. M was seen by Dr. Jimerson at Advanced Plastic Surgery Solutions on May 14, 2018. She was interested in Brazilian Butt Lift (BBL) and 360 Liposuction. She had previously undergone the following cosmetic surgeries: BBL w lip abd in December 2017; silicone injection and then removed by the same doctor in April 2017; labiaplasty in 2010; and smart lip of thighs in 2016. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 1, 2, 16, 21, 79, 113, 135, 563)

19.

After consultation and submission of required forms, including a Medical Clearance/Surgical Clearance Form completed by Dr. Jhurani of Piedmont Physicians, Ale. M was scheduled to undergo surgery on October 2, 2018. At the time Dr. Jhurani completed the exam on September 19, 2018 for the Medical Clearance/Surgical Clearance form, ALE. M's hemoglobin was 14. (Testimony of Respondent; Joint Exhibit pp. 4, 7, 15, 19)

20.

Prior to surgery, Ale. M signed an Informed Consent Form. This form, along with other provisions, informed Ale. M that it is possible, but unusual, to experience a bleeding episode during or after surgery that could result in requiring a blood transfusion, although such occurrences are rare. It further informed Ale. M that increased activity too soon after surgery can lead to increased chance of bleeding and, thus, it is important to follow postoperative instructions and

[5] Joint Exhibit pp. 1-757

limit exercise and strenuous activity for the instructed time. Additionally, the provision instructs the patient to not take aspirin or anti-inflammatory medications for at least 10 days before or after surgery as this could increase the risk of bleeding, and further that non-prescription "herbs" and dietary supplements can also increase the risk of surgical bleeding. Finally, the provision states that a hematoma can occur at any time, usually in the first three weeks following injury to the operative area. (Joint Exhibit pp. 27, 29, 37, 39, 47, 49)

21.

During surgery, through several small stab wounds, a tumescent solution was infiltrated under low pressure and then using a 4mm and 3mm cannulas aspiration of fat was carried out in the same order as the infiltration. The fat was harvested under low pressure in a sterile manner and mixed with an antibiotic solution. The aspirate was allowed to separate with gravity and then the tumescent fluid was drained off leaving viable, healthy fat cells to be grafted to the butt and hips. (Joint Exhibit pp. 83, 85)

22.

Ale. M underwent a significant liposuction of 5,000 cc's in and 5,000 cc's out. The current body of medical literature has shown that lipoaspirate greater than 5,000 cc's comes with higher rates of complications. Thus, several practices, including Northside Hospital, limits plastic surgeons to no more than 5,000 cc's of lipoaspirate. In Ale. M.'s case, Respondent noted that he had reached the maximum recommended 5,000 cc's out prior to completing every scheduled procedure so he decided to not complete liposuction of Ale. M's arms and instead planned to refund her for one area of liposuction.[6] At the conclusion of the surgery, Respondent estimated Ale. M's blood loss to be 150 cc's with no complications. (Testimony of Dr. Kavali; Testimony of Dr. Constantino

[6] Dr. Mendieta believes that Respondent must have been concerned and was proactive in choosing to not proceed with completing liposuction of the arms because of what he was seeing during surgery. (Testimony of Dr. Mendieta)

Mendieta; Testimony of Respondent; Joint Exhibit pp. 83-84)

23.

On October 8, 2018, Ale. M contacted Respondent's office to state she had a fever of 102 all weekend and warm spots on her buttocks. She was instructed to come into the office but said she had no one to take her there. Respondent then advised Ale. M to go to the emergency room and she stated that she could go to Wellstar Cobb hospital since it was closer to her home. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 90, 107)

24.

At Wellstar Cobb hospital a computed tomography imaging study (CT) was completed. It showed fat stranding in the buttocks, which according to Dr. Kavali is sort of a non-specific finding because it could have been related to infection or could have been related to postoperative changes due to the recent surgery. There is no evidence that Respondent injected fat into Ale. M.'s gluteus muscles. (Testimony of Dr. Kavali)

25.

When Ale. M. presented at Wellstar Cobb hospital her hemoglobin was 8.8. She was later admitted to Emory Johns Creek Hospital that same day "for antibiotics and pain management" to address fever and elevated white blood cell count due to post-operative infection/sepsis. Her hemoglobin when checked at Emory Johns Creek Hospital had dropped to 7.7 and then dropped further to 7.2.[7] It then reached a high of 8.9 on October 11 but dropped to 7.8 on the day of discharge, October 12. Respondent believes that Ale. M. would not have needed a blood transfusion at a hemoglobin level of 8.8 or even 7.7 but given that Ale. M. was admitted to Wellstar and then Emory Johns Creek where she likely received fluids that would cause hemodilution and cause her hemoglobin

[7] Normal readings for hemoglobin are between 11.1 and 15.9 g/dL. (Joint Exhibit p. 8)

to drop is part of the reason she was provided a blood transfusion. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 94, 97, 107, 114, 115, 144, 157, 198, 225, 253, 283, 284, 715, 745, 756).

26.

While being treated at Emory Johns Creek Hospital, Petitioner was diagnosed with postoperative anemia, among other things. Due to the postoperative anemia the hospital provided 1 unit of packed red blood cell transfusion. (Testimony of Dr. Kavali; Joint Exhibit pp. 110, 111, 143, 179, 183, 225, 226, 284, 295, 517)

Patient Ali. M

27.

Patient Ali. M. was seen by Dr. Jimerson at Advanced Plastic Surgery Solutions on April 17, 2018. She was interested in a tummy tuck, breast lift with implants, Brazilian Butt Lift and 360 liposuction. Although she had a history of prior medical surgeries, she had no history of cosmetic surgery. (Testimony of Dr. Kavali; Joint Exhibit pp. 759-761, 775, 777, 780, 862, 866, 895)

28.

During Ali. M.'s consultation on April 17, Respondent advised her that to optimize her surgical results she should reduce her weight by 45 pounds. He did not recommend the weight loss for safety or medical purposes but rather to help her achieve the aesthetic look she hoped to have. The plastic surgery field states it is safe to conduct surgeries at outpatient surgical centers if an individual's BMI is below 40. Ali. M.'s BMI was 34.45 so it was not a safety consideration that Respondent recommended weight loss but, rather, for aesthetic purposes that Respondent recommended she lose 45 pounds. By the time of surgery less than a month later Ali. M. had not lost the suggested amount of weight. (Testimony of Dr. Kavali; Testimony of Respondent; Joint

Exhibit pp. 761)

29.

Ali. M.'s surgery was scheduled for May 10, 2018. She completed a physical exam with Jeannie Wallace, PA-C, on April 24, 2018, for her medical clearance for surgery. Her hemoglobin result, from a collection taken the day before on April 23, was 12. (Testimony of Dr. Kavali; Joint Exhibit pp. 763-764, 770, 774, 853)

30.

Prior to surgery, Ali. M signed Informed Consent that advised of potential bleeding issues that, although rare, can occur. (Joint Exhibit pp. 785, 796, 806, 816, 826, 901, 911, 990, 1000, 1010)

31.

Ali. M. underwent a significant plastic surgery procedure involving a total of 5,000 cc's, the maximum recommended by the industry. Respondent estimated Ali. M.'s total blood loss to be 200 cc's. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 867, 871) Her PACU hemoglobin reading was 9.8. She was not symptomatic at that time so there was no reason/need to treat the lower hemoglobin count as it is expected the hemoglobin will drop during surgery. (Testimony of Dr. Kavali; Testimony of Dr. Constantino Mendieta; Testimony of Respondent; Joint Exhibit pp. 874)

32.

At Ali. M.'s post-operative follow-up appointment on May 15, 2018, her hemoglobin reading was 7.8 and she had a near syncopal episode upon her arrival for her massage appointment. She advised that she felt she needed to go to the hospital because she did not think she could provide herself proper nutrition and hydration. She then went to Johns Creek Emergency Department and while there her hemoglobin dropped to 6.6, which Respondent believes may have been caused by

hemodilution, meaning that the fluids she was given at the hospital diluted her blood and caused her hemoglobin reading to drop. She was diagnosed with anemia, received a blood transfusion of 2 units, and was subsequently discharged on May 19, 2018, with her hemoglobin around 8.6. (Testimony of Dr. Kavali; Testimony of Dr. Mendieta; Testimony of Respondent; Joint Exhibit pp. 875-877, 879, 884, 1087, 1103, 1112, 1113, 1175, 1177, 1181, 1399, 1488, 1492)

33.

Emory Johns Creek Hospital documentation for Ali. M. included information regarding anemia. It explained that anemia can occur for many reasons, including following surgery and if an individual has low iron levels. (Joint Exhibit pp. 1190)

34.

Ali. M. elected to undergo another procedure on October 23, 2018. Specifically, she was seen for fat grafting to the butt with liposuction of her abdomen, flanks, back bra roll and lower back. Due to her anemia and prior need for a blood transfusion she was required to increase her iron intake to qualify to have a second surgery. She had labs run by Memorial Women's City Center on October 4, 2018, at which time her hemoglobin registered at 11.6. (Testimony of Dr. Kavali; Joint Exhibit pp. 887, 892, 936, 957)

35.

Respondent performed Ali. M.'s surgery on October 23, 2018, as scheduled. At the conclusion of the surgery, Respondent estimated Ali. M.'s blood loss during surgery to be 250 cc's. (Testimony of Dr. Kavali; Joint Exhibit pp. 947, 949)

36.

The following day, on October 24, 2018, Ali. M. was not feeling well and went to Gwinnett Medical Emergency Room. Her hemoglobin registered at 8.8. (Joint Exhibit pp. 953) The next

day, October 25, she was seen at Advanced Plastic Surgery Solutions. Her hemoglobin at this time registered 7.4. While there, her hemoglobin dropped to 5.7, at which time Dr. Gordon ordered that she be transported to Emory Johns Creek Hospital for a blood transfusion. (Testimony of Dr. Kavali; Joint Exhibit pp. 955, 958)

37.

Ali. M. was admitted to Johns Creek Hospital on October 25, 2018. She was discharged the following day on October 26. During her stay she was diagnosed as anemic and received a blood transfusion of 2 units of packed red blood cells. Her hemoglobin at time of admission was 7.5. Within 24 hours, Ali. M.'s hemoglobin increased to 9.5. (Testimony of Dr. Kavali; Joint Exhibit pp. 1065, 1069, 1073, 1492, 1495, 1513, 1542, 1551-1552).

38.

By October 29, Ali. M. reported feeling much better after receiving 3 units of packed red blood cells. (Joint Exhibit pp. 959)

39.

Despite not being satisfied with the results of her prior surgeries, Ali. M. elected to undergo a third operation on April 16, 2019, to have fat grafting to butt and hips, SAL capsulectomy right breast, and excision of back bra roll. During her medical clearance exam on or about April 4, 2019, her hemoglobin registered 12.5. (Testimony of Dr. Kavali; Joint Exhibit pp. 965, 968, 971, 1049)

40.

The April 16, 2019, surgery was again significant involving a total of 5,750 cc's. (Joint Exhibit 1048) At the conclusion of the April 16, 2019 surgery, both Respondent and the anesthesiologist estimated Ali. M.'s blood loss to be 400. (Testimony of Dr. Kavali; Joint Exhibit pp. 1040, 1048)

41.

Following the third surgery, Ali. M. was satisfied with the results. (Joint Exhibit pp. 1058).

Patient G.R.

42.

Patient G.R. was seen at Advanced Plastics Surgery Solutions by Dr. Jimerson on January 10, 2017, for a body cosmetic evaluation of her abdomen, flanks, and back. (Testimony of Dr. Kavali; Joint Exhibit p. 1678)

43.

She had previously undergone a breast reduction 20 years prior, and abdominoplasty in 2007. (Joint Exhibit p. 1679)

44.

Respondent advised G.R. that she should reduce her weight by 15 pounds prior to surgery "to optimize her surgical result." Respondent's recommendation was not made for safety or medical concerns but so she could have a better aesthetic outcome. However, at her next appointment on February 21, 2017, G.R.'s weight had increased by 19 pounds and her Body Mass Index (BMI) had increased to 34.30. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 1679, 1698)

45.

Dr. Kavali opined that Respondent's treatment of G.R. fell below the minimum standard of care, in part, because he proceeded with her surgery even though she had not lost the weight that he had recommended she lose to optimize surgical outcomes. (Testimony of Dr. Kavali). Respondent testified that it is safe to operate on a person who has a BMI under 40 at an outpatient setting, and that he had recommended a reduction in weight not for the safety of the patient but to optimize the

surgical results to meet her desire to look a certain way. (Testimony of Respondent)

46.

G.R. was seen by Dr. Kim Kubar on February 21, 2017. She was medically cleared by Dr. Kubar for the elective surgery. Her hemoglobin at that time registered 11.4. (Joint Exhibit pp. 1681-1682, 2429)

47.

Prior to surgery, G.R. signed an Informed Consent Form. This form, along with other provisions, informed G.R. that it is possible, but unusual, to experience a bleeding episode during or after surgery that could result in requiring a blood transfusion, although such occurrences are rare. It further informed G.R. that increased activity too soon after surgery can lead to increased chance of bleeding and, thus, it is important to follow postoperative instructions and limit exercise and strenuous activity for the instructed time. Additionally, the provision instructs not to take aspirin or anti-inflammatory medications for at least 10 days before or after surgery as this could increase the risk of bleeding, and further that non-prescription "herbs" and dietary supplements can also increase the risk of surgical bleeding. Finally, the provision states that a hematoma can occur at any time, usually in the first three weeks following injury to the operative area. (Joint Exhibit pp. 1723, 1734, 1744, 1753, 1763)

48.

On March 14, 2017, Respondent completed G.R.'s surgery for brachioplasty, breast implant, breast lift, and liposuction of back bra roll. (Joint Exhibit pp. 1788, 2431, 2433) Her surgery involved a total of 4000 cc's in and 4000 cc's out. (Joint Exhibit p. 1789) Following the surgery, the anesthesiologist estimated G.R.'s blood loss to be 400. (Testimony of Respondent; Joint Exhibit p. 1782) Her hemoglobin was checked prior to discharge and registered 10.2. (Testimony of

Respondent; Joint Exhibit p. 1795, 2442)

49.

G.R. was seen on March 20, 2017, for a post-op visit. During this visit, she advised she was not doing well, was very fatigued, and was not eating adequately because of poor appetite. She further advised that her caregiver left after 3 days post-operation and she had been caring for herself, which goes against medical advice because it is not safe to drive or to care for yourself after extensive surgery. She received fluids via IV but continued to complain of fatigue, so Respondent sent G.R. to Emory Johns Creek Hospital for further evaluation and treatment of symptoms. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 1797-1799, 1885)

50.

G.R. was admitted to Emory Johns Creek Hospital on March 20, 2017, due to generalized weakness, fever, sepsis, and anemia. She was discharged on March 23. During her stay, her treatment included an order for a blood transfusion as recommended by Respondent. However, overnight "she possibly had a transfusion reaction, became tachycardic, tachypneic, and very anxious," so the transfusion was deferred and did not occur. While at the hospital, G.R.'s hemoglobin decreased from 8.3 to 7.8, possibly due to hemodilution. A few days later, on March 29, 2017, G.R.'s hemoglobin registered 8.9. Her discharge diagnosis included anemia secondary to blood loss intraoperatively plus or minus anemia of chronic inflammation. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 1806-1809, 1811, 1820, 1828, 1833, 1838, 1846, 1898, 1905, 1931-1932, 1949, 1958, 1971, 1999-2002, 2006, 2011, 2017-2018, 2204, 2209, 2363)

51.

G.R. was subsequently seen at and treated by Johns Creek Wound Care, and Dr. Herman of

Lansdale Institute of Plastic Surgery in Landsdale, Pennsylvania. On or around May 1, 2017, Dr. Herman performed exploration of breasts with debridement of fibrinous and necrotic tissue with drain placement and breast complex closure. (Joint Exhibit pp. 1849-1878)

Patient L.L.

52.

L.L. was seen by Dr. Jimerson on or about July 3, 2018, for a consult regarding abdominoplasty and liposuction with gluteal fat transfer. Respondent recommended a full tummy tuck, fat grafting to buttocks and hips, and 360 Liposuction of the abdomen, flanks, lower back and front bar rolls, arms, inner thighs, and upper back. (Testimony of Dr. Kavali; Joint Exhibit p. 4337)

53.

L.L.'s primary care physician cleared her as low risk for elective surgery, and her hemoglobin was within normal range prior to surgery. (Testimony of Dr. Kavali; Testimony of Respondent)

54.

L.L. underwent surgery on September 6, 2018. Her surgery took 3.5 hours under general anesthesia during which 5L of lipoaspirate was removed after infusion of 5L of tumescent fluid and a total of 2L of fat was transferred into the buttocks and hips. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 4423-4424, 4428)

55.

Although Respondent had planned on using cell saver, he ultimately did not use it because of the minimal blood loss during surgery. Respondent estimated blood loss for L.L. was 100 cc's, while the nurse anesthetist's notes indicate that he/she estimated L.L.'s blood loss to be less than 300 cc's. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 4434-4435)

56.

Dr. Kavali opined that Respondent's estimate could not have been accurate because a loss of 100 cc's would not result in a person being subsequently diagnosed with postoperative anemia. Instead, Dr. Kavali believes that L.L.'s interoperative blood loss was most likely excessive, and that Respondent failed to accurately identify the excessive blood loss which caused L.L. to need to go to the hospital within a few days of her surgery and receive a blood transfusion. (Testimony of Dr. Kavali; Joint Exhibit pp. 4434-4435)

57.

Around postoperative day two, LL presented to Gwinnett Medical Center after passing out twice. L.L. was transferred to Emory Johns Creek Hospital and was found to have symptomatic postoperative anemia with a hemoglobin reading of 6.8. As a result of the postoperative anemia L.L. required a blood transfusion of three units of red packed blood cells. The hospital also completed imaging that showed an abdominal wall hematoma. A hematoma can cause anemia if it is large enough and could possibly explain L.L.'s anemia despite the minimal blood loss Respondent estimated occurred during surgery. (Testimony of Dr. Kavali; Testimony of Respondent)

Patient T.P.

58.

T.P. was seen by Respondent on June 15, 2018, for consult regarding abdominoplasty, liposuction, and gluteal fat transfer. (Testimony of Dr. Kavali; Joint Exhibit p. 4948)

59.

Her history was significant for requiring a blood transfusion after a prior breast reduction surgery. She also has heavy periods and history of anemia related to that. Despite this history, her

hemoglobin prior to surgery was 12.3, which is within the normal range. Her hematologist deemed T.P. to be "medically optimized" and low risk to proceed with elective surgery. (Testimony of Dr. Kavali; Testimony of Respondent)

60.

T.P. underwent surgery on October 19, 2018. During surgery, Respondent recorded 5L lipoaspirate. The operative report indicates an estimated blood loss of 500 cc's. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 5052, 5058)

61.

After surgery, in the recovery room, T.P.'s hemoglobin registered 10.2. However, while still in the recovery room, T.P. stood up and had a near syncopal episode. Respondent then ran T.P.'s blood again and got a hemoglobin reading of 7.4. Respondent later opined that the second hemoglobin reading was probably a false reading because when T.P. was transported to Emory Johns Creek Hospital her hemoglobin registered at 9.1. It would not be likely that her hemoglobin was 7.4 at the PACU and then 9.1 a short while later at the hospital so it was likely that the second PACU reading was a false reading. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 5053)

62.

At Emory Johns Creek T.P. was found to have symptomatic postoperative anemia. The day after being admitted, T.P.'s hemoglobin dropped to 7.7. While being treated at Emory Johns Creek Hospital, T.P. received a blood transfusion of two units. (Testimony of Dr. Kavali; Testimony of Respondent)

Patient J.L.

63.

J.L. was seen at Advanced Plastic Surgery Solutions on May 24, 2018. She was subsequently seen by Respondent on June 4, 2018. Respondent's medical records from both visits indicate J.L. has a history of anemia, iron deficiency among other conditions. She also had gastric bypass in 2011, and a history of plastic surgery from 2012 and 2016. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 2990-2991, 2993-2994)

64.

After consultation, Respondent recommended a full tummy tuck; 360 liposuction, abdomen, flanks, lower back, back bra roll, arms, and upper back, revision of navel, and excision of dog ears bilateral. (Joint Exhibit p. 2995)

65.

On June 8, 2018, J.L.'s hemoglobin registered at 10.6. Subsequently, J.L.'s medical clearance form, completed on August 7, 2018, by Orlando Veterans Administration, indicated that J.L.'s hemoglobin was 11.1 and that she was at low risk for elective surgery. (Testimony of Respondent; Joint Exhibit pp. 3000, 3003, 3062)

66.

J.L. completed her pre-operative appointment on August 20, 2018. At that time, she signed consent forms in which she was informed about issues with bleeding that, although rare, could arise. (Joint Exhibit pp. 3028, 3038, 3048, 3117, 3127, 3136)

67.

J.L. underwent surgery on August 21, 2018, for abdominoplasty and liposuction with gluteal fat transfer. Respondent recorded 5L of lipoaspirate and 2200 cc of fat transferred to the buttocks

during J.L.'s surgery.[8] J.L.'s estimated blood loss from surgery was 200 cc's. Following the surgery, J.L.'s hemoglobin registered 9.5.[9] (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 3067, 3073-3079)

68.

The next day, on August 22, 2018, J.L. presented to Emory Johns Creek Hospital with fever, chills, and dizziness. J.L. was found to have symptomatic postoperative anemia with a hemoglobin reading of 6.3, a significant drop of 3.2 in a 24-hour period. The anemia caused J.L. to suffer an acute renal insufficiency due to lack of adequate oxygen. J.L. received a blood transfusion of 3 units while being treated at Emory Johns Creek Hospital. She was discharged on August 24, 2018. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 3080, 3091, 3093-3096, 3101)

69.

Respondent opined that part of the issue that arose in this case was because J.L. previously had undergone gastric bypass. Since then, Respondent has changed his practice procedures when dealing with patients who have undergone gastric bypass because based on research Respondent has completed, he learned that patients with a history of gastric bypass are more prone to fluid shift so he no longer performs high level liposuction procedures on patients with a history of gastric bypass surgery. (Testimony of Respondent)

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[8] Respondent testified, in response to a question asking him to confirm that the surgery involved 2800 ccs in and 2800 ccs out rather than 5000 ccs, that the suggestion was correct. However, the page that Respondent and his attorney referenced, that being 3226 in the Joint Exhibit, relates to a surgery that took place in June 2019 and not to the surgery at issue in the Matters Asserted, which was completed on August 21, 2018. (Testimony of Respondent; Joint Exhibit pp. 3073-3079 and 3226).

[9] Respondent testified to J.L.'s hemoglobin in the PACU after the June 2019 surgery, which registered 11.3, but does not relate to the August 21, 2018, surgery at issue in the Matters Asserted. (Testimony of Respondent; Joint Exhibit p. 3231)

Patient I.B.

70.

I.B. was seen by Respondent on March 23, 2018, for a Brazilian Butt Lift with liposuction of hips and also a breast lift and surgical correction of her flat buttocks. (Testimony of Dr. Kavali; Joint Exhibit p. 2448).

71.

Respondent's weight assessment of I.B. included a notation that I.B. must gain 10 pounds prior to surgery. (Joint Exhibit p. 2450). I.B. weighed 151 pounds on March 23, 2018, and weighed 157 pounds on April 16, the date of surgery. (Joint Exhibit pp. 2449, 2542)

72.

I.B.'s medical clearance form was completed by Georgia Highlands Medical Services on March 26, 2018, and indicates she is medically low risk for elective surgery. The attached lab results show I.B.'s hemoglobin to be 12.2. (Testimony of Respondent; Joint Exhibit pp. 2451-2453).

73.

I.B. participated in pre-operative appointments on April 2 and April 13. Respondent's medical records indicate that I.B. would undergo surgery on April 16 for the following procedures: fat grafting to the butt and hips with lip of abdomen, flanks, lower back, upper back, back bra roll., in addition to breast augmentation with breast lift. (Joint Exhibit pp. 2458, 2461)

74.

Prior to surgery, I.B. signed informed consent forms that included information on possible issues with post-operative bleeding. The consent forms indicate it is possible but rare to need a blood transfusion after surgery and that the risk of bleeding is increased if the individual increases activity too soon after surgery or takes aspirin or anti-inflammatory medications within 10 days

before or after surgery, or if an individual takes non-prescription "herb" or dietary supplements. The consent form further reiterates the need to follow post-operative care instructions and to limit exercise and strenuous activity. (Joint Exhibit p. 2473, 2483, 2493, 2503)

75.

I.B. underwent surgery on April 16, 2018. Respondent recorded 5000L in and 5000L out. Respondent estimated I.B.'s blood loss to be <300cc. In the recovery room, prior to discharge, I.B.'s hemoglobin registered 8.7. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit pp. 2539-2553)

76.

I.B.'s menstrual period started two days after surgery on April 18, 2018. Menstrual periods can affect a person's hemoglobin levels. (Testimony of Dr. Constantino Mendieta; Testimony of Respondent; Joint Exhibit p. 2562)

77.

On April 18, 2018, I.B. came to Respondent's office for a post-op visit. Respondent's medical records for I.B. reflect that she was seen by Dr. Gordon, who noted she had a temperature of 99 and had early cellulitis on her buttocks. She was prescribed an antibiotic, had the affected area marked with a surgical marker, was instructed to wash the area, and was further instructed to watch the area to ensure the redness did not increase. (Testimony of Respondent; Respondent's Exhibit 1)

78.

On April 22, 2018, I.B. presented to Emory Johns Creek Hospital for buttock pain and fever for the past five days and was admitted to the hospital. She was subsequently discharged on April 26, 2018. I.B. was found to have symptomatic postoperative anemia with a hemoglobin count of 8.9

upon admission that subsequently dropped to 7.6 while I.B. was at Emory Johns Creek Hospital. I.B. received a blood transfusion of one unit to treat the postoperative anemia. Her hemoglobin registered 9.6 at time of discharge. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 2556-2557, 2561, 2565, 2569-2570, 2573, 2586, 2590, 2596, 2602-2603, 2606, 2625, 2634, 2646-2647, 2668, 2679, 2681-2684, 2874, 2982)

Patient K.L.

79.

K.L. was seen by Respondent on or about December 9, 2016. (Testimony of Dr. Kavali)

80.

Prior to surgery, K.L.'s hemoglobin reading was 11.5. (Testimony of Respondent)

81.

K.L. underwent surgery on April 19, 2017, for breast reduction, abdominoplasty, and liposuction with gluteal fat transfer. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 3710)

82.

K.L.'s surgery took 5 hours. Respondent recorded 5L lipoaspirate and 2100 cc of fat transfer to the buttocks. Respondent estimated K.L.'s blood loss to be 400 cc's. (Testimony of Dr. Kavali)

83.

Postoperative day one K.L.'s spouse contacted Respondent's office to say that K.L. was feeling lightheaded and dizzy so Respondent advised she should go to the emergency room. K.L. presented to the emergency department and her hemoglobin reading was 8.5. While at the hospital, K.L.'s hemoglobin dropped, and she was subsequently diagnosed with symptomatic postoperative anemia with a hemoglobin of 7.6. K.L. received a blood transfusion of 2 units of blood. At the

hospital, the attending doctor indicated that the anemia may not be related to surgery because it was determined that she had a tick bite two days prior to surgery. A tick bite can cause anemia due to Lyme disease; however, Dr. Kavali believes that K.L.'s acute blood loss during surgery is what caused her hemoglobin to drop to 7.6 because her anemia was acute and occurred immediately postoperative. (Testimony of Dr. Kavali; Testimony of Respondent; Joint Exhibit p. 3735)

84.

Approximately, 11 days later K.L. was admitted to the hospital for lethargy and was found to have symptomatic postoperative anemia with a hemoglobin of 7.3 and given another transfusion of 2 units of blood. (Testimony of Dr. Kavali)

Technique and Cell Saver

85.

Liposuction has various techniques that can be employed including dry, wet, super wet, and tumescent. The different techniques refer to the ratio of tumescent fluid infiltrated to reduce blood loss during liposuction. No one uses the dry technique any longer. The super wet is the most common technique used and involves infiltrating 1 cc of tumescent for every 1 cc aspirate removed. Using the super wet technique should result in a blood loss of approximately 1 percent of the lipoaspirate. (Testimony of Dr. Kavali; Testimony of Respondent; Testimony of Dr. Earl Stephenson, Jr.)

86.

Cell saver is a device that can be used during surgery to collect blood waste, spin it down, and then reinject the patient's own blood through an IV before they leave the operating room. It is a way to preserve the patient's blood and minimize blood loss. It is not required under the standard of

care so using it would be considered to be going above and beyond the minimal standard of care because the physician chose to invest money on an expensive piece of equipment to try to minimize his/her patient's blood loss during surgery. (Testimony of Dr. Kavali; Testimony of Dr. Constantino Mendieta; Testimony of Respondent; Testimony of Dr. Earl Stephenson, Jr.).

87.

For each of the patients referenced above, Respondent used the super wet technique, and for most of his patients he also used cell saver. Respondent chose to use cell saver when appropriate to help minimize the blood loss of his patients during surgery. Dr. Kavali noted that despite Respondent's use of cell saver he still had eight (8) patients suffer from postoperative anemia, which again leads her to believe that there was a problem somewhere. (Testimony of Dr. Kavali; Testimony of Dr. Mendieta; Joint Exhibit p. 15, 19, 84, 762, 853, 1048, 2548, 3075)

88.

Respondent testified that the American Society of Plastic Surgeons says when estimating blood loss using a specific formula and the super wet technique the blood loss should be approximately 1 to 3 to 4 percent of the total aspirate. The difference between estimating 1 to 3 to 4 percent is typically done by looking at the color of the aspirate. Respondent further testified that trying to reach an exact number for estimated blood loss is not significantly important because what is more important is whether a patient is displaying symptoms and if a surgeon is concerned about the patient the surgeon can obtain a hemoglobin level. This is true, in part, because the number is typically so inaccurate given that it is determined by "eyeballing" it and visually estimating based on the color of the aspirate and the formula referenced above of 1 to 4 percent of the aspirate. Dr. Mendieta and Dr. Stephenson both concurred that a surgeon would treat symptoms rather than a specific number reached in estimating blood loss because estimating blood loss is not an exact

science. (Testimony of Respondent; Testimony of Dr. Mendieta; Testimony of Dr. Stephenson)

Respondent's Process

89.

Around 2017 to 2018, several plastic surgeons who perform high level liposuction noticed an increase in patients suffering from postoperative anemia. (Testimony of Dr. Mendieta; Testimony of Respondent)

90.

Respondent met with his quality assurance team to discuss the issue they were seeing in his practice among his patients. He also conducted a study of his surgeries/patients "to try to figure out what was going on" because he had not seen this issue before. He made the decision to invest in cell saver at that time as an intervention to address the issue. However, the issue continued. So, he talked with colleagues, completed a retrospective chart review, and started getting hemoglobin levels in the PACU. Respondent determined the postoperative anemia could not be related to intraoperative blood loss because by using the super wet technique and cell saver the blood loss during surgery should be minimal and thought "it has to be something else." Respondent believed that something must be going on during the postoperative period and completed a literature search and researched other specialties like orthopedics to try to figure it out. He noted that orthopedic surgeons were experiencing the same issue and were treating it by using tranexamic acid. He also read two articles in the Plastic and Reconstructive Surgery journal about tranexamic acid. Respondent then began using it and noticed an immediate drop in his complication rate. (Testimony of Respondent)

91.

Currently, prior to beginning surgery, Respondent maintains a list that summarizes information for

each patient scheduled for surgery on a particular day, including listing the patient's hemoglobin reading. (Testimony of Respondent; Respondent's Exhibit 8)

92.

Additionally, currently Respondent's staff preps a dry-erase board in the operation room that specifies the areas that will be addressed and how much tumescent fluid will be injected (TFI) and then afterwards notes how much tumescent fluid has come out (TFO). (Testimony of Respondent; Respondent's Exhibits 3 and 7). The staff can calculate exactly how much tumescent fluid is injected because, at the start of surgery, the bags of tumescent fluid are laid out and each one is exactly 1 liter. (Testimony of Respondent; Respondent's Exhibit 4). The staff can also calculate exactly how much tumescent fluid has come out based on the aspirate collected in the sterile canister that lists measurements directly on the canister. (Testimony of Respondent; Respondent's Exhibits 5 and 6)

Third Spacing

93.

Dr. Kavali testified that third spacing is the gathering of fluid or the movement of fluids from intravascular to extravascular. For example, if a person has been in an airport all day and has swollen ankles that reflects third space fluid – it is fluid in the tissues rather than in the vascular space. When fluid is in the tissues it is not providing oxygen. However, Dr. Kavali testified that third spacing is not applicable in this matter because the airport example involves interstitial fluid increase and not blood in a third space. Instead, when blood is in a third space it is a hematoma or a bruise. (Testimony of Dr. Kavali)

94.

Moreover, third spacing would not impact a doctor's calculation of estimated blood loss because

blood loss during surgery comes from blood on lap sponges, or on the floor, or blood in a canister. Although it is typical for a patient to have bruising following surgery, the estimated blood loss would not include this loss of blood into a patient's tissues because blood in the tissues is a bruise or a hematoma and not considered third spacing. (Testimony of Dr. Kavali)

95.

According to Dr. Mendieta he considers third spacing to be a potential issue with certain techniques because of the possible dilution effect. For example, when you give a person a lot of fluids that fluid can go under the fatty layers, basically it can go outside the vessels and into the body. A few days after surgery that's when all the fluid goes back into the vessels and dilutes the blood causing hemoglobin to drop. So, although a person may appear to be stable when discharged home from the surgical center, it is possible that a few days later they could experience a drop in their hemoglobin levels because of the effects of the dilution. (Testimony of Mendieta)

Accreditation of Solutions Surgical Center

96.

At the time relevant to the issues in this matter, Respondent served as Facility Director of Facility No. 5566/Solutions Surgical Center located at 6620 McGinnis Ferry Road, Johns Creek, GA 30097, which at the time was accredited through the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Solutions Surgical Center was first accredited by AAAASF in 2009. (Testimony of Dr. Monte Jay Goldstein, an anesthesiologist, and a director of AAAASF; Exhibit P-4)

97.

AAAASF is a national accrediting agency that accredits ambulatory surgical centers and office space practices over a multitude of programs. It grants accreditation to facilities that "meet and

maintain 100% compliance with its accreditation standards." (Testimony of Dr. Goldstein; Exhibit P-4)

98.

On July 9, 2019, AAAASF conducted an unannounced survey of Respondent's surgical center after receiving a letter from Emory Johns Creek Hospital regarding several of Respondent's patients presenting to the emergency room within a week of elective surgery at Solutions Surgical Center. Subsequently, on October 15, 2019, AAAASF notified Respondent that the surgical center was "placed on immediate emergency suspension due to the serious nature of deficiencies cited during July 9, 2019 survey." The attached Statement of Deficiency alleges, among other things, that the facility failed to remove outdated medications because a vial of ketamine was found with a date of July 1, 2019; that the facility failed to have medical records that were legible, documented and completed accurately because one male patient's records noted "she" and ten patient records suggested that the amount of tumescent injected equaled the amount of aspirate removed for all sites which the individual completing the survey apparently believed was not physically possible; and that the facility did not document perioperative bleeding risk including medical conditions and medication taken up to the day of procedure. (Testimony of Dr. Goldstein; Exhibit P-4).

99.

AAAASF allows facilities to appeal adverse actions. Dr. Monte Jay Goldstein, a director on AAAASF's board, is not aware of Respondent filing an appeal as the Facility Director of Solutions Surgical Center regarding the October 15, 2019, immediate emergency suspension. (Testimony of Dr. Goldstein)

100.

Following the adverse action, Respondent obtained privileges at another surgical center that is

accredited by AAAASF. He also has hospital privileges at Northside to be able to continue performing surgeries. Additionally, Respondent obtained accreditation for Solutions Surgical Center through AAAHC, another accreditation agency. (Testimony of Respondent)

Petitioner's Allegations Regarding Respondent's Treatment of Identified Patients

101.

Petitioner asserts that Respondent's treatment of the aforementioned patients departed from and failed to conform to the minimum standards of acceptable and prevailing medical practice due to:

(1) Respondent's failure to accurately assess their intraoperative blood loss;

(2) Respondent injecting fat into the gluteus muscles of Ale. M.;

(3) Respondent proceeding with operating on Ali M. and G.R. without those patients first achieving the weight loss that Respondent recommended; and

(4) Respondent's records not reflecting how he managed I.B.'s fever for five days following surgery.

(Statement of Matters Asserted Paragraphs 3, 5, 7, 9, 12, 14, 16, and 18)

Respondent's Expert Witnesses

102.

Constantino Mendieta, M.D., is a board-certified plastic surgeon currently licensed in Florida, California and Arizona. He was previously licensed to practice in Georgia as well. He earned his medical degree from Creighton University School of Medicine in 1989. His post graduate education included a Fellowship in Plastic Surgery in 1994, a Plastic and Reconstructive Surgery Residency from 1995 to 1997 at the University of Miami/Jackson Memorial Hospital, and three separate Fellowships in Aesthetic Surgery in 1998 in California, Georgia and at Harvard Medical School in Cambridge, Massachusetts. He is Board-certified in plastic and reconstructive surgery.

He is a member of several professional affiliations, has received various awards, has been published on a variety of topics including authoring "The Art of Gluteal Sculpting," and has taught other physicians at various symposiums and annual meetings of professional affiliations. (Testimony of Dr. Constantino Mendieta; Exhibit R-2).

103.

Dr. Mendieta's main specialty is gluteal contouring, which is also referred to as Brazilian Butt Lift or fat grafting to the buttocks. He has performed over 9,000 surgeries in this area. Dr. Mendieta is also well-known in the area of liposuction and was recently named #1 on Newsweek's list of America's Best Plastic Surgeons 2022 in the area of Liposuction. He has performed between 15,000 to 18,000 surgeries involving liposuction. (Testimony of Dr. Mendieta)

104.

Based on his training and experience, Dr. Mendieta is familiar with the minimum standards of acceptable and prevailing medical practice for plastic surgery involving extensive liposuction of up to 5,000 cc's of aspirate. (Testimony of Dr. Mendieta; Exhibit R-2)

105.

Dr. Mendieta reviewed the medical records of Respondent's patients at issue in this matter. Based on his review, he opined that the records do not establish that Respondent failed to meet the minimum standards of acceptable and prevailing medical practice for plastic surgery. He further opined that Respondent's post-operative anemia rate of less than 2% of patients who underwent surgeries during the time period in question was lower than the national average of 3 to 5 percent and would support the conclusion that blood transfusions are rare as indicated in Consent Forms for liposuction. It also would not be an indication that Respondent must have miscalculated estimated blood loss and/or failed to meet the minimum standard of care. (Testimony of Dr.

Mendieta).

106.

Dr. Mendieta testified that hemoglobin count is an issue for a lot of plastic surgeons who perform BBL and extensive liposuction (5000 ccs). Dr. Mendieta has divided it into three stages – blood beforehand, blood during surgery, and blood after surgery. Beforehand surgeons should get a basic panel of bloodwork to look at hemoglobin to make sure there is no bleeding tendencies or gross anemia and that the patient is starting off at a good level. Respondent did obtain preoperative hemoglobin levels for his patients and each patient had a hemoglobin within normal range prior to surgery. In the second stage, blood will be lost during surgery simply because of the procedure being done. The surgeon then makes a visual estimate of the blood loss. Respondent entered into his patients' medical records an estimated blood loss that occurred during surgery. (Testimony of Dr. Mendieta).

107.

When estimating blood loss after surgery the intention is not to get an exact number since it is an estimation. Rather, the intention is to ensure there has been no excessive blood loss during the surgery and, if there was, to treat it appropriately. It is typical after surgery for a patient's hemoglobin to be in the range of 8, 9 or 10. It is also typical for a patient to continue to have their hemoglobin drop 2 to 3 units during the week after surgery. So, primarily when estimating blood loss the surgeon should really be ensuring that when the person is discharged from the surgical center their hemoglobin is not likely to be in the range of 5 or 6, which would be dangerous levels. Respondent did check the hemoglobin of some patients' post-surgery and all showed readings within the allowable range of 8 to 10. (Testimony of Dr. Mendieta)

108.

Dr. Mendieta noted that a lot of plastic surgeons don't specialize in body contouring BBL and those surgeons would not be familiar with the complications with performing the higher-level liposuctions. If a plastic surgeon is only removing 1, 2 or 3 liters they are unlikely to see post-operative anemia issues. However, a lot of surgeons who do the higher levels of liposuction involved with BBL are more likely to see the post-operative anemia issues. Some surgeons who performed these higher-level liposuctions had 2 to 5 percent of their patients suffer from post-operative anemia so Respondent's rate of complication would not be atypical. (Testimony of Dr. Mendieta).

109.

Dr. Mendieta also noted there are at least three reasons a person's hemoglobin may continue to drop after surgery and ultimately reach a dangerous level of 6 or lower even though the patient did not experience significant blood loss during surgery. First, the hemoglobin could have dropped due to a dilution effect because of the high level of fluids that were injected into the patient prior to surgery that could have gone out of the vessels and into the body and then returned to the vessels a few days after surgery. Second, the significant level of liposuction completed is traumatic to the body and could cause continued slow internal oozing after surgery. Finally, the body does not make red blood cells quickly. In addition, if a patient experiences her period around the time of surgery or shortly afterwards it would affect the patient's hemoglobin. Thus, Dr. Mendieta opined that Respondent could have estimated each patient's blood loss accurately and still had several patients experience post-operative anemia. He further opined that if hemoglobin levels dropped due to dilution or oozing of blood or slow reproduction of red blood cells it is not reflective of a doctor failing to meet the minimal standards of acceptable and prevailing medical practice.

(Testimony of Dr. Mendieta)

110.

Earl Stephenson, Jr., M.D., is a licensed surgeon in Georgia and has held a license since 1998. He earned his Doctor of Dental Surgery (D.D.S.) from the University of Oklahoma College of Dentistry in 1990, and subsequently earned his Doctor of Medicine (M.D.) from the Eastern Virginia School of Medicine in 1997. He is Board Certified in Oral and Maxillofacial Surgery and Plastic Surgery. He is a member of several professional organizations, has received numerous honors and awards, and has presented at various seminars. He has worked in the field of plastic surgery since 2006. He has been board certified since around 2007. (Testimony of Dr. Earl Stephenson, Jr.; Respondent Exhibit 10).

111.

Dr. Stephenson's practice consists of approximately 65% cosmetic surgery and 35% reconstructive surgery. The cosmetic surgery includes breast lifts, breast reduction, tummy tucks, and liposuction. He also does BBL/fat grafting to the buttocks, which constitutes about 10% of the 65% of his cosmetic surgeries. (Testimony of Dr. Stephenson)

112.

Dr. Stephenson reviewed Respondent's medical records at issue. Based on his review, Dr. Stephenson opined that Respondent did not fail to comply with the standard of care in estimating intraoperative blood loss. (Testimony of Dr. Stephenson)

113.

Dr. Stephenson testified that estimating blood loss is a nuanced science. A surgeon considers the amount of blood lost in the field, the blood in the sponges and how much is saturated there, and the amount estimated to be in the aspirate. Using those measures, and speaking with the

anesthetists, the surgeon makes an estimate. Moreover, when using the super wet technique, the estimate of blood lost intraoperative is expected to be within the range of 1% to 5% of the aspirate. (Testimony of Dr. Stephenson)

114.

When a patient moves to the PACU, it is standard of care to assess the patient, not necessarily the blood loss. A surgeon should be driven by symptoms. For example, if a patient is dizzy or unstable, the surgeon should consider the physical assessment along with any type of lab data he/she may have. (Testimony of Dr. Stephenson)

115.

When undergoing surgery there is an expectation that hemoglobin will drop because of the blood loss from surgery as well as hemodilution due to the fluids injected into the patient. Postoperative a patient can continue to lose blood through oozing or slow leak into the tissues, which is why surgeons continue to monitor patients postoperative. This can lead to blood loss or lower hemoglobin that is not related to intraoperative blood loss. (Testimony of Dr. Stephenson)

116.

Dr. Stephenson did not see anything in Respondent's medical records that would indicate that the intraoperative blood loss was not estimated correctly. He further opined that the postoperative anemia that the patients at issue experienced did not relate back to the estimated blood loss reached by Respondent post-surgery. Dr. Stephenson acknowledged that if a surgeon failed to estimate blood loss and failed to look at the blood in the sponges and the amount of aspirate and the amount of blood in the field then it could result in harm to a patient. However, his review of Respondent's records showed that Respondent and the anesthetist estimated blood loss and, in his opinion, met the standard of care. If, like Respondent, you obtain a hemoglobin reading and it is within the

expected range for post-surgery and the patient is asymptomatic then it is reasonable and within standard of care to discharge the patient from the outpatient surgical center. Furthermore, when Respondent had a patient who did present with symptoms, that being a near syncopal episode, he sent her to the hospital as would be expected as standard of care. (Testimony of Dr. Stephenson; Testimony of Respondent; Joint Exhibit p. 5053)

Petitioner's Request for Hospital Information for May 2018-May 2021

117.

In May 2021, Petitioner sent a request to three hospitals located in the vicinity of Respondent's practice asking for "complete medical records for patients that initially were seen at Advanced Plastic Surgery Solutions, and specifically seen by Andrew Jimerson, M.D., and who underwent elective aesthetic surgery and then subsequently presented at" the hospital's emergency department requiring blood transfusions during the past three years, May 2018-May 2021. Two hospitals responded. One had no records and the other hospital had five records. This would not account for individuals, if any, who may have presented at other hospitals or who presented at one of the two hospitals that responded but the hospital was unaware or did not record that the individual had been seen by Respondent. (Petitioner's Exhibits P-6, P-7, and P-8; Respondent's Exhibit 9)

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:

> Engaged 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) (emphasis added).

4.

In turn, 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:

> (7) Engaged 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) (emphasis added)

5.

Similarly, Ga. Comp. R. & Regs. 360-3-.02(18) authorized the Board to take disciplinary action against a licensee for unprofessional conduct, which is defined as, among other things, "[a]ny 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.

Finally, Petitioner is authorized to discipline a licensee upon a finding by the board that the licensee has failed to maintain appropriate medical or other records as required by board rule. O.C.G.A. 43-34-8(a)(19); Ga. Comp. R. & Regs. 360-3-.02(16) (failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response).

8.

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.

9.

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.

10.

In this matter, Petitioner alleges that Respondent's treatment and/or diagnosis of the patients referenced in the Findings of Fact, above, departed from and failed to conform to the minimum standards of acceptable and prevailing medical practice due to Respondent's failure to accurately assess and record his patients' intraoperative blood loss. The Court concludes that the evidence presented does not establish this allegation. Although Dr. Kavali testified about her concerns regarding Respondent having eight (8) patients over a 19-month period present to the emergency room and be diagnosed with postoperative anemia that the hospital chose to treat with a blood transfusion, she could not explain what Respondent had done that departed from or failed to conform to the minimum standards of acceptable and prevailing medical practice. Instead, Dr. Kavali could only say that Respondent must have done "something" wrong to end up with multiple patients being diagnosed with postoperative anemia. However, the Court concludes that Dr. Mendieta and Dr. Stephenson's testimony provided credible alternative factors/theories of what could have led to these eight (8) patients experiencing postoperative anemia other than an alleged misestimation of intraoperative blood loss. Moreover, the Court concludes that Dr. Mendieta and Dr. Stephenson's opinion testimony that Respondent did not depart or fail to conform to the minimum standards of acceptable and prevailing medical practice to be more persuasive. This is especially true given Respondent's decision to employ the super wet technique and to also use cell saver when appropriate to help minimize his patients' blood loss during surgery. Additionally, Respondent sometimes obtained hemoglobin levels post-surgery prior to discharge to check his patients' levels, which were within the range expected for post-surgery. The Court further concludes that it is within standard of care to treat symptoms and that there is no evidence that

Respondent ignored or failed to assess his patients' status post-surgery. In fact, when a patient did present with symptoms, he acted within standard of care by providing fluids and monitoring the patient and/or having the patient go to the emergency room. Thus, based on the foregoing, the Court concludes that the evidence presented does not establish that Respondent engaged in unprofessional conduct in violation of O.C.G.A. §§ 43-1-19(a)(6), 43-34-8(a)(7), and Ga. Comp. R. & Regs. 360-3-.02(18). It has not been shown that Respondent's practices departed from, or failed to conform to, the minimum standards of acceptable and prevailing medical practice regarding his treatment of the identified patients between 2017 and 2018.

11.

Petitioner also alleges that Respondent's treatment of Ale. M. departed from and failed to conform to the minimum standards of acceptable and prevailing medical practice due to Respondent injecting fat into the gluteus muscles. There is no evidence in the record to support this allegation. Thus, Petitioner failed to meet its burden as to this allegation.

12.

Petitioner also alleges that Respondent's diagnosis and treatment of patients Ali. M. and G.R. departed from and failed to conform to the minimum standards of acceptable and prevailing medical practice due to Respondent proceeding with their surgeries without either patient first achieving the recommended weight loss. There is no evidence in the record that performing elective cosmetic surgery at an outpatient surgical center on a patient with a BMI below 40 departs from or fails to conform to the minimum standards of acceptable and prevailing medical practice. Respondent recommended that these two patients lose weight to optimize their surgical results that they hoped to achieve and not for safety or medical purposes. Thus, Petitioner failed to meet is burden as to this allegation.

Petitioner also alleges that Respondent's records did not reflect how Respondent managed patient I.B.'s fever for five days following surgery. For unknown reasons, I.B.'s record entry from April 18, 2018, showing she was seen by Dr. Gordon who diagnosed I.B. with cellulitis, prescribed an antibiotic, marked the area, and provided instructions to I.B. regarding infections, was not provided to Petitioner along with the other records. However, the Court finds credible that this record existed at or around the time of the visit. Thus, the Court concludes that Respondent's records did reflect how Respondent managed patient I.B.'s fever following surgery.

III. Decision

Based on the foregoing, the Court recommends that **NO DISCIPLINARY ACTION** be taken against Respondent and that **NO SANCTIONS** be imposed against his medical license.

SO ORDERED, this 24th day of October, 2022.

Ana-Beatriz Kennedy
Administrative Law Judge

NOTICE OF INITIAL DECISION

Attached is the Initial Decision of the administrative law judge. A party who disagrees with the Initial Decision may file a motion with the administrative law judge and/or an application for agency review.

Filing a Motion with the Administrative Law Judge

A party who wishes to file a motion to vacate a default, a motion for reconsideration, or a motion for rehearing must do so within 10 days of the entry of the Initial Decision. Ga. Comp. R. & Regs. 616-1-2-.28, -.30(4). All motions must be made in writing and filed with the judge's assistant, with copies served simultaneously upon all parties of record. Ga. Comp. R. & Regs. 616-1-2-.04, -.11, -.16. The judge's assistant is Devin Hamilton - 404-657-3337; Email: devinh@osah.ga.gov; Fax: 404-657-3337; 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303.

Filing an Application for Agency Review

A party who seeks review by the referring agency must file an application for agency review within 30 days after service of the Initial Decision. O.C.G.A. §§ 50-13-17(a), -41. **In nearly all cases, agency review is a prerequisite for judicial review.** O.C.G.A. § 50-13-19(a).

The application for agency review must be filed with: . Copies of the application for agency review must be served upon all parties of record and filed simultaneously with the OSAH Chief Clerk at 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303. If a timely application for agency review is not filed and the referring agency does not review the Initial Decision on its own motion, the Initial Decision will become the Final Decision of the referring agency by operation of law. O.C.G.A. §§ 50-13-17(a), -41.

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

IN THE MATTER OF:	)		GEORGIA COMPOSITE MEDICAL BOARD
JENNIFER MILLER RAFUS, License No. 374 (Lapsed),	)	DOCKET NO:	NOV 10 2022
Reinstatement Applicant.	)		DOCKET NUMBER: 20230030

PUBLIC CONSENT AGREEMENT FOR REINSTATEMENT

Pursuant to O.C.G.A. Title 43, Chapters 1 and 34, the Georgia Composite Medical Board ("Board"), in its discretion, has considered the reinstatement application for licensure of JENNIFER MILLER RAFUS ("Applicant") to practice as an acupuncturist in the State of Georgia. In conjunction therewith, the Board hereby enters its Findings of Fact and Conclusions of Law as follows:

FINDINGS OF FACT

1.

On or about August 6, 2015, Applicant was issued a license to practice as an acupuncturist in the State of Georgia. On July 31, 2019, Applicant's license expired, and was subsequently revoked by operation of law for non-renewal.

2.

Applicant engaged in the unlicensed practice of acupuncture following the expiration of her license until in or about July, 2022.

3.

Applicant admits to the above findings of fact, and waives any further findings of fact with respect to this matter.

CONCLUSIONS OF LAW

Reinstatement of a license is within the discretion of the Board. Applicant's unlicensed practice is grounds for denial of reinstatement or licensure with discipline under O.C.G.A. Ch. 34, T. 43, as amended. Applicant waives any further conclusions of law with respect to the above-styled matter.

ORDER

Beginning on the effective date of this Consent Agreement, Applicant's license to practice as an acupuncturist in the State of Georgia shall be reinstated, subject to the following terms:

1.

Within three (3) months of the effective date of this Consent Agreement, Applicant shall submit to the Board a fine of two thousand dollars ($2,000.00) for her unlicensed practice. The fine shall be paid in full by cashier's check or money order made payable to the Georgia Composite Medical Board, and sent to Georgia Composite Medical Board, 2 Peachtree Street, NW, 6th Floor, Atlanta, Georgia 30303, to the attention of the Executive Director. Failure to pay the entire amount within three (3) months shall be considered a violation of this Agreement and shall result in further sanctioning of Applicant's licensure, including revocation, upon substantiation thereof.

2.

Within one (1) year of the effective date of this Consent Agreement, Applicant shall submit to the Board evidence of her completion of an additional fifty-two (52) hours of Board-approved continuing acupuncture education. These hours may not be used to satisfy continuing education requirements for future license renewal. Failure to provide evidence to the Board of

completion of these hours within one (1) year shall be considered a violation of this Agreement and shall result in further sanctioning of Applicant's licensure, including revocation, upon substantiation thereof.

3.

Applicant shall abide by all state and federal laws regulating the practice of acupuncture, the Rules and Regulations of the Board, and the terms and conditions of this Consent Agreement. If Applicant shall fail to abide by such laws, rules, terms or conditions of this Consent Agreement, Applicant's license shall be subject to further discipline, including revocation, upon substantiation thereof after notice and hearing; and if revoked, the Board in its discretion may determine that the license should be permanently revoked and not subject to reinstatement.

4.

Approval of this Consent Order by the Board shall not be construed as condoning Applicant's conduct and shall not be construed as a waiver of any of the lawful rights possessed by the Board.

5.

Applicant acknowledges that Applicant has read this Consent Agreement and understands its contents. Applicant understands that Applicant has the right to an appearance in this matter, and freely, knowingly and voluntarily waives that right by entering into this Consent Agreement. Applicant understands and agrees that the Board shall have the authority to review the Board's files and all relevant evidence in considering this Consent Agreement. Applicant further understands that this Consent Agreement will not become effective until approved and docketed by the Board. Applicant understands that this Consent Agreement, once approved and docketed, shall constitute a public record, evidencing disciplinary action by the Board that may be

disseminated as such. However, if this Consent Agreement is not approved, it shall not constitute an admission against interest in this proceeding, or prejudice the right of the Board to adjudicate this matter. Applicant hereby consents to the terms and sanctions contained herein.

Approved this 10th day of November, 2022.

(BOARD SEAL)

GEORGIA COMPOSITE MEDICAL BOARD

BY: _____
MATTHEW W. NORMAN, M.D.
Chairperson

ATTEST: _____
DANIEL R. DORSEY
Executive Director

CONSENTED TO:

_____
JENNIFER MILLER RAFUS
Applicant

[As to Applicant's signature:]
Sworn to and subscribed before me
This 28th day of October, 2022.

_____
NOTARY PUBLIC
My Commission Expires:

ANGEL K. ENNIS NOTARY PUBLIC EXP. OCT. 4, 2025 WARE COUNTY, GA