1606_7778_050405
STATE OF TENNESSEE
DEPARTMENT OF HEALTH

IN THE MATTER OF:	)	**BEFORE THE BOARD OF**
	)	**MEDICAL EXAMINERS**
CHARLES HARLAN, M.D.	)	
RESPONDENT	)	**DOCKET NO. 17.18-022307A**
	)	
NASHVILLE, TENNESSEE	)	
LICENSE NUMBER 7778	)	

FINAL ORDER

This matter came to be heard before the Tennessee Board of Medical Examiners on May 19, 2003, May 20, 2003, May 21, 2003, June 18, 2003, July 15, 2003, July 16, 2003, July 17, 2003, July 18, 2003, July 29, 2003, July 30, 2003, August 19, 2003, August 20, 2003, August 21, 2003, December 11, 2003, May 26, 2004, July 15, 2004, July 16, 2004, August 2, 2004, August 3, 2004, August 4, 2004, August 30, 2004, August 31, 2004, October 18, 2004, October 19, 2004, March 14, 2005, March 15, 2005, April 18, 2005, April 19, 2005, April 20, 2005 and April 21, 2005 pursuant to a Notice of Charges filed by the Tennessee Department of Health. The panel of Board members hearing this matter consisted of Nina Yeiser, Chair, Sam Barnes, M.D., and Allen Edmonson, M.D. Presiding at the hearing was the Honorable Tom Stovall, Administrative Law Judge, assigned by the Secretary of State. The Department of Health was represented by Robert A. O'Connell, Assistant General Counsel and Laurie Lea Doty, Deputy General Counsel. After consideration of the Notice of Charges, testimony of witnesses, arguments of counsel, and the record as a whole, the Board finds as follows:

II. FINDINGS OF FACT

1. On September 27, 1999, the family of the deceased (M.L.) requested that the Respondent send official documentation to the Bank of America branch in Madison, Tennessee to verify M.L.'s death.

a. In the Respondent's first response to the inquiry, the Respondent wrote "M.L. is dead" on a blank piece of paper and faxed it to the bank.

b. When the Respondent's note was insufficient for their purposes and an additional request was made for a more definite statement, the Respondent wrote on his letterhead, "M.L. is dead. She is green and has maggots crawling on her" and faxed it to the bank.

2. On October 26, 1997, the Respondent performed an autopsy on the body of D.D. In the autopsy report, he listed the cause of death as Sudden Infant Death Syndrome, despite reporting the unexplained presence of cocaine and cocaine metabolites in the child's urine and alcohol in the child's blood.

a. During the Respondent's testimony at the murder trial, the Respondent stated that the sample he drew was contaminated by his use of a dirty instrument causing the cocaine and alcohol to be found.

b. When asked, upon cross-examination, why he had not explained in his autopsy report that the finding of cocaine in the child's urine was a result of contamination, the Respondent said: "Because I didn't choose to do that. The reason for that is by explaining or showing the presence of contamination in the sample, then it

throws other cases in this state into a position where they can be challenged going back to 1939."

c. The father confessed to giving the child alcohol and blowing marijuana smoke in the child's face (with the possibility that the marijuana was laced with cocaine).

d. When the Respondent failed to include in his autopsy report for D.D. his opinion regarding the contamination of the fluid samples, he violated the standard of care for forensic pathologists.

3. The Respondent performed an autopsy on the body of J.K.S. on January 23, 2001. The child was fifteen (15) months old at the time of his death. The Respondent listed the cause of death as a subdural hematoma, secondary to a complex linear skull fracture, secondary to an accelerated fall.

a. Upon injury, the child was taken to Maury County Regional Hospital where medical records indicate that the child's injuries were possible child abuse. The child was transferred by life flight to Huntsville Hospital where the child expired.

b. The Respondent held himself out to be an Assistant Medical Examiner for Maury County and signed an Order for Autopsy.

c. The Respondent subsequently attempted to have the pediatric neurosurgeon in Huntsville change the Alabama death certificate to reflect the Respondent's opinion as to the manner of death. The surgeon refused.

d. The Respondent then caused a Tennessee death certificate to be issued stating that the child died in Maury County, Tennessee and listing the cause of death as consistent with the Respondent's opinion when he knew that the child did not die in Tennessee.

e. The Respondent's opinion as it relates to the cause and manner or death of this child is inconsistent with the medical proof, which was available to him at the time of his autopsy. The child's actual manner of death was a result of non-accidental trauma.

f. Despite the fact that an investigation was being conducted into possible child abuse and despite the presence of a prior leg fracture, the Respondent's autopsy was not sufficiently thorough. For example, the Respondent failed to perform a skeletal survey or X ray the entire body.

g. In his Autopsy Report, in the Narrative Findings, the Respondent wrote:

> The manner of death is accident. Unfortunately, history is replete with insufficiently-trained pediatricians, medical examiners, hospital and state agencies that would mistakenly misinterpret the medical history and information from the autopsy and police investigations, with resultant erroneous conclusion (see medical literature and the Discovery Channel).

4. On April 16, 2002, D.P. died of an apparent heart attack at his home outside Woodbury, in Cannon County, Tennessee. His widow was concerned that the death might have been the result of foul play. She wanted an autopsy conducted on her husband's body but wanted someone other than the Respondent to perform the autopsy as she did not trust him to perform it competently.

a. While the body was in transit to the Office of the Chief Medical Examiner for the State of Tennessee for autopsy by Dr. Bruce Levy, the Respondent learned of the situation and demanded that the body be diverted to him as he had the contract with Cannon County to perform autopsies.

b. Contrary to the widow's wishes, the body was sent to the Respondent. He performed the autopsy and immediately destroyed the organs while lab results were still pending.

c. When asked about this act by an acquaintance two days later, he replied that the law was on his side, that he had gotten everything done, and that Dr. Levy was not going to get the opportunity to do a second autopsy.

d. Dr. Levy was, in fact, unable to conduct a second autopsy because of the failure of Dr. Harlan to preserve the organs. On April 19, 2002, Dr. Levy inspected the body but was limited to a brief external examination and drawing fluid from the eyes. D.P. was buried without his organs in Cannon County on April 22, 2002.

5. On May 9, 2002, Tina Marcy of Maury County, Tennessee, discovered, attached to the undercarriage of her automobile, an object which the Columbia Police Department Bomb Squad identified as a tracking device.

a. Upon questioning by law enforcement, the Respondent admitted to having secretly attached the device to the woman's car.

b. The Respondent was charged with the commission of a Class C misdemeanor (TENN. CODE ANN. 39-13-606, Electronic Tracking of Motor Vehicles), punishable by up to thirty (30) days in jail or a fine of up to $50.00 or both.

6. On August 20, 2001, A.M.L. died, an apparent victim of a traffic accident, on I-24 in Robertson County, Tennessee.

a. Assistant District Attorney General Joel Perry signed an Order for Autopsy, instructing the Respondent to perform an autopsy on A.M.L.

b. The Respondent performed the autopsy on August 20, 2001 and completed his Autopsy Report on April 25, 2002. He then sent the autopsy report to District Attorney General John Carney (received in that office on or about April 30, 2002) for payment. The Order for Autopsy which accompanied the autopsy report and which is required for payment was not the Order originally sent to the Respondent. In its stead the Respondent had substituted an Order for Autopsy, signed by Assistant District Attorney Dent Morris, ordering the Respondent to conduct an autopsy on a different individual, M.R.B. The Respondent had altered a copy of M.R.B.'s autopsy order, changing the date from "8-11-01" to "10/30/2001," changing the deceased from "M.R.B." to "A.M.L." and keeping the signatures of Dent Morris and Detective M. Carlisle, when, in fact, Mr. Morris and Mr. Carlisle never signed an order dealing with A.M.L.

7. On January 19, 1995, the Respondent performed an autopsy on the body of K. A. According to the autopsy report submitted by the Respondent, it was determined that the cause of death was a result of a seizure, as the deceased had a history of cerebral palsy.

a. An Order Directing Disinterment and Autopsy was entered on March 3, 1998 and as a result a second autopsy was performed.

b. The results of the second autopsy indicated that the cause of death was in fact severe blunt trauma to the calvarium, with extensive subarachnoid and at least some degree of subdural hemorrhages over much of the brain, even about the brain stem. The manner of death was determined to be homicide.

c. The second autopsy revealed that the Respondent had performed an inadequate examination of the lungs as well as an inadequate gross and microscopic examination.

d. The second autopsy determined that the Respondent failed to adequately record his findings on his autopsy report.

8. On June 17, 1995, the Respondent performed an autopsy of the body of L.P. listing the cause of death as blunt trauma to the head.

a. The Respondent's autopsy report fails to indicate any bruising or any fractures to the child's ribs or arms. The Respondent also found that the manner of death was accidental, consistent with the mother's reported statement that the child had fallen from a car seat. The anatomical diagnoses in the Respondent's autopsy report included right subgaleal hematoma (30 cc), right parietal linear skull fracture, bilateral temporal cerebral cortical contusions (left greater than right), right subdural hematoma (40 cc, partially gelled), and right parietal scalp contusion.

b. The body was subsequently exhumed and a second autopsy performed because the initial treating physician believed that the child died as a result of child abuse.

c. The second autopsy was reviewed by two (2) forensic pathologists, and both concurred that the child's death was a result of child abuse.

d. The second autopsy revealed that the child had multiple rib fractures including a large displaced fracture involving the posterior portion of the left seventh rib, fractures to both arms, a second non-displaced linear skull fracture, and a finding that the

first skull fracture was indicative of inflicted rather than unintentional injury. The report further concluded that there were gross discrepancies in the initial autopsy report.

e. On May 22, 1997, the father of the child, Cedric D. Phelps, was convicted of her first degree murder and sentenced to life imprisonment.

9. On July 12, 1995, the Respondent performed an autopsy on the body of F.M., who died at age ten (10) weighing eighteen (18) pounds.

a. The Respondent listed her cause of death as malnutrition, dehydration and muscle wasting, secondary to bacterial meningitis in early childhood, with no mention of abuse or neglect.

b. The social and medical history of this child revealed that a sibling had died a year earlier from meningitis.

c. When the deceased was found, she had maggots in her soiled diaper and on her body.

d. When she was discovered, she was home alone with her eight-year old brother, who was attempting to perform C.P.R. She was described in the hospital narrative as being "grossly malnourished."

e. At the hearing in this matter, the Respondent admitted telling Detective JoAnn Gregory, who was investigating F.M.'s case, that:

(i) F.M. was lucky to have lived as long as she did;

(ii) She didn't feel any pain; and

(iii) She was going to die anyway.

10. On April 3, 1997 and April 4, 1997, the Respondent performed autopsies on the bodies of James C. and John C.

a. These individuals were two (2) of the six (6) inmates who were killed in a motor vehicle accident in Dickson County.

b. The bodies of all of the inmates killed were burnt beyond normal methods of recognition.

c. In the autopsy reports, the Respondent stated that he relied on dental records to identify the bodies.

d. However, prior to writing the autopsy reports for James C. and John C., the Respondent had no dental records of either decedent to use in identifying their bodies.

e. The bodies were misidentified and sent to the wrong families for burial.

f. Both bodies were still in shackles when sent by the Respondent to the families after the autopsies.

11. On July 14, 1997, the Respondent performed an autopsy on a body that he identified as B.L.

a. The remains of the body, burned beyond recognition, had been found in a vehicle which had been set on fire.

b. The Respondent identified the body through the use of dental records (specifically, tooth number thirty-one [31]).

c. At the time of B.L.'s alleged death, he was facing numerous criminal charges.

d. In 1999, B.L. (using an alias) was arrested after a traffic stop. After questioning, his correct identity was determined. He is presently incarcerated in the federal prison system.

e. Subsequent review of the Respondent's findings by a forensic odontologist revealed that the Respondent misidentified the tooth he used to make the identification.

f. The Respondent subsequently stated that B.L.'s tooth thirty-one (31) had been implanted in the mouth of the unknown victim. Actually, the tooth remains to date where it has always been, in B.L.'s mouth.

12. On October 19, 1998, the Respondent performed an autopsy on the body of H.S.H., age thirty-four (34). Prior to conducting an autopsy, the Respondent opined that the cause of death was multiple stab wounds.

a. The Respondent's findings after autopsy are listed as stab wound to chest, and the Respondent's narrative findings indicated that the deceased had received multiple stab wounds, including a stab wound to the posterior right chest, producing injury to the right lung, bleeding and death.

b. A review of the Respondent's findings by a forensic pathologist revealed that the Respondent's conclusions with regard to the cause of death were inconsistent with his own lab analyses and that the cause of death was actually injuries sustained by the deceased days prior to his death. Further, the stab wounds that the Respondent found at autopsy were actually cuts from a glass table that the deceased fell on when he died.

c. Despite the Respondent's erroneous findings, the defendant in this matter was acquitted of first-degree murder charges.

13. On January 31, 2000, the Respondent performed an autopsy on the body of E.S.S. listing the cause of death as hyperpyrexia, secondary to cerebral edema and gastric hemorrhage, secondary to fall, secondary to acute and chronic ethanolism.

a. In the Respondent's narrative findings he stated that E.S.S. died as a result of bleeding caused by the consumption of too much alcohol.

b. The Respondent's autopsy report indicated that the blood alcohol level was negative.

c. Prior to his death, E.S.S. was treated at Bedford Hospital where a meningitis screen was performed and was positive for Neisseria meningitis.

14. On March 24, 2000, the Respondent performed an autopsy on the body of M.J. and ruled that the cause of death was status epilepticus secondary to an epileptic seizure disorder.

a. Prior to the Respondent's autopsy showing the cause of death as status epilepticus, there was no indication that M.J. had a history of epilepsy.

b. The Chief Medical Examiner for the State of Tennessee reviewed the Respondent's autopsy of M.J. and the investigation into the circumstances surrounding his death. He concluded that M.J. died as a result of left ventricular hypertrophy or enlargement of his heart.

c. There was no history of epilepsy and the witnesses to the deceased's terminal event did not see any seizure activity. Therefore, the finding that the death resulted from epilepsy is not supported.

15. On April 5, 2000, the Respondent performed an autopsy on the body of K.M. listing the cause of death as an overdose of phentermine. K.M. was forty (40) years old at the time of her death.

a. The toxicology specimens were not submitted to the TBI toxicology laboratory until May 19, 2000, more than six (6) weeks after the autopsy was performed.

b. The Respondent issued a death certificate on October 18, 2000 listing the cause of death as an amitriptyline overdose and the manner of death as suicide.

c. On January 18, 2001, toxicology results were issued, and no amitryptyline was present in K.M.'s body. Toxicology found phentermine in K.M.'s body.

d. The Respondent's autopsy report lists the cause of death as "overdose of phentermine" and his narrative states that the blood levels were "more than thirty (30) times the normal or therapeutic level." In fact, the phentermine level was only between two (2) and three (3) times the normal therapeutic level.

e. Further, the Respondent initially issued an autopsy report for K.M. in the name of P.A.P.

f. The Respondent has never issued a corrected death certificate as it relates to K.M. or P.A.P.

g. When asked at the hearing in this matter why he did not wait for the toxicology report to come back before issuing a death certificate listing a definite cause of death, the Respondent testified that he was "being pressed by the family to give them some kind of death certificate". He admitted that his listing of amitriplyline overdose as the cause of death was incorrect. He further admitted that he "should have issued one (the death certificate) that said pending toxicology."

h. When asked at the hearing in this matter about inaccuracies in autopsy report, the Respondent testified to the following:

(i) It was his responsibility to ensure that the autopsy report in this case was correct;

(ii) He sometimes reads his autopsy report before he signs it and sometimes does not, depending upon "the particular case"; and

(iii) He did not think he read the autopsy report in K.M.'s case before he signed it.

16. Sudden Infant Death Syndrome was officially defined in 1989 by a conference at the National Institutes of Health as "the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including the performance of a complete autopsy, examination of the death scene, and a review of the clinical history. Cases failing to meet the standards of this definition, including those without a post-mortem examination, should not be diagnosed as SIDS.

17. The Respondent performed an autopsy on the body of E.A.M.B. on April 13, 2000. The child was forty-one (41) days old, and the cause of death was listed as Sudden Infant Death Syndrome. The circumstances include:

a. Dr. Michael Green, an eye doctor, saw the child in his office, examined her, administered Tropicamide 1%, two drops per eye.

b. After leaving the office, the mother noticed a small amount of blood around E.A.M.B.'s nose. A short time later, she noticed more blood from E.A.M.B.'s nose and mouth.

c. The mother then took E.A.M.B. back to Dr. Green's office. A nurse noticed that the baby was not breathing, and CPR was started.

d. All of the above circumstances were included in the autopsy order received by the Respondent.

18. The Respondent performed an autopsy on J.C. on December 24, 2000. The child was fifteen (15) months of age, and the Respondent listed the cause of death as acute bronchopneumonia, secondary to sudden infant death. The Respondent's autopsy report does not contain the results of the required testing to be performed pursuant to the definition set out above and the standards of practice applicable to forensic pathologists in Tennessee. The sudden infant death diagnosis was made despite the one year age limit. In addition, the SIDS diagnosis was inappropriate and incorrect considering the finding of acute bronchopneumonia.

19. The Respondent performed an autopsy on H.P.R. on November 4, 2000. This child was two (2) months old, and the cause of death was listed as Sudden Infant Death Syndrome. The Respondent's autopsy report does not contain the results of the testing relative to diffuse interstitial pneumonitis.

20. The Respondent performed an autopsy on G.M.D. on December 3, 2000. The child was two (2) months old, and the Respondent listed the cause of death as Sudden Infant Death Syndrome. Prior to the child's death, she had a temperature of 106 degrees. The Respondent's autopsy report does not contain testing beyond the routine.

21. On March 10, 1997, the Respondent performed an autopsy on the body of V.C., listing the cause of death as Sudden Infant Death Syndrome.

a. Law enforcement investigation revealed that the child was in the care of M.J., who was out on bond having been charged with the murder of another child in her care who died as a result of shaken baby syndrome.

22. On April 29, 1997, the Respondent performed an autopsy on the body of D.R. and listed the cause of death as Sudden Infant Death Syndrome. The deceased was three (3) weeks of age at the time of his death.

a. At the time of the child's death, law enforcement officials observed blood on the child's nose and clothing when they arrived upon the scene. The mother of the child also had a history of drug use, and his father was in prison for having raped the deceased's brother.

c. The Respondent listed SIDS as the cause of death even though his autopsy report also notes pulmonary edema and the autopsy order notes blood on the clothing.

23. On January 3, 2000, the Respondent performed an autopsy on the body of J.C.W. and listed the cause of death as Sudden Infant Death Syndrome. The child was six (6) months of age upon her death.

a. The Order for Autopsy stated that the child was found lying between the wall and a daybed.

b. Despite the information indicating positional asphyxiation, the Respondent listed the cause of death as Sudden Infant Death Syndrome.

III. CONCLUSIONS OF LAW

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24. Section 63-6-214 of the Tennessee Code Annotated (hereinafter "TENN. CODE ANN.") and Rule 0880-2-.12 of the *Official Compilation of Rules and Regulations of the State of Tennessee* (hereinafter *"O.C.R.R.S.T."*) grant the Tennessee Board of Medical Examiners (the Board) the power to suspend, revoke or otherwise discipline a licensee

who has violated the provisions of Title 63, Chapter 6 of the Tennessee Code or the regulations duly promulgated by the Board.

25. The Board may initiate a civil penalty assessment with respect to any person required to be licensed by it. The amount of said penalty may not exceed one-thousand ($1,000) dollars for each separate violation of the provisions of a statute, rule or order pertaining to the Board. TENN. CODE ANN. § 63-1-134(a) (2004) and Rule 0880-2-.12 of the *O.C.R.R.S.T.*

26. Civil penalties assessed pursuant to this section shall become final thirty (30) days after the date a final order of assessment is served. TENN. CODE ANN. § 63-1-134(c)(1) (2004) and Rule 0880-2-.12 of the *O.C.R.R.S.T.*

27. If the violator fails to pay an assessment when it becomes final, the division may apply to the appropriate court for a judgment and seek execution of such judgment. TENN. CODE ANN. § 63-1-134(c)(2) (2004) and Rule 0880-2-.12 of the *O.C.R.R.S.T.*

28. The Board may, whenever a final order is issued after a disciplinary contested case hearing which contains findings that a licensee has violated any provision of Title 63, Chapter 6, assess the costs directly related to the prosecution of the case against the licensee. TENN. CODE ANN. § 63-6-214(k) (2004) and Rule 0880-2-.12(j) of the *O.C.R.R.S.T.*

29. The Board concludes that the facts contained in ¶¶ 1(a)(b), 2(a)(b)(c)(d), 3(a)(b)(c)(d)(e)(f)(g), 5(a)(b), 9(a)(b)(c)(d)(e), 10(a)(b)(c)(d)(e)(f), and 15(a)(b)(c)(d)(e)(f)(g)(h) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such

acts or omissions would constitute unprofessional conduct. *See* TENN. CODE ANN. § 63-6-214(b)(1).

30. The Board concludes that the facts contained in ¶¶ 3(a)(b)(c)(d)(e)(f)(g), 5(a)(b), and 10(a)(b)(c)(d)(e)(f) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute dishonorable conduct. *See* TENN. CODE ANN. § 63-6-214(b)(1).

31. The Board concludes that the facts contained in ¶¶ 2(a)(b)(c)(d), 3(a)(b)(c)(d)(e)(f)(g), and 10(c)(d) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute making false statements or representations. *See* TENN. CODE ANN. § 63-6-214(b)(3).

32. The Board concludes that the facts contained in ¶¶ 3(a)(b)(c)(d)(e)(f)(g) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute fraud or deceit. *See* TENN. CODE ANN. § 63-6-214(b)(3).

33. The Board concludes that the facts contained in ¶¶ 11(a)(b)(c)(d)(e)(f) and 12(a)(b)(c) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute malpractice. *See* TENN. CODE ANN. § 63-6-214(b)(4).

34. The Board concludes that the facts contained in ¶¶ 2(a)(b)(c)(d), 3(a)(b)(c)(d)(e)(f)(g), 7(a)(b)(c)(d), 8(a)(b)(c)(d)(e), 10(a)(b)(c)(d)(e)(f), 12(a)(b)(c), 14(a)(b)(c), 15(a)(b)(c)(d)(e)(f)(g)(h), 20, and 23(a)(b) constitute acts or omissions which

would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute negligence. *See* TENN. CODE ANN. § 63-6-214(b)(4).

35. The Board concludes that the facts contained in ¶¶ 13(a)(b)(c), 14(a)(b)(c), 15(a)(b)(c)(d)(e)(f)(g)(h), 18, 22(a)(c), and 23(a)(b) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute incompetence. *See* TENN. CODE ANN. § 63-6-214(b)(4).

36. The Board concludes that the facts contained in ¶¶ 3(a)(b)(c)(d)(e)(f)(g) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute making or signing in one's professional capacity any certificate that is known to be false at the time one makes or signs such certificate. *See* TENN. CODE ANN. § 63-6-214(b)(11).

37. The Board concludes that the facts contained in ¶¶ 3(a)(b)(c)(d)(e)(f)(g) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute the violation or attempted violation, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any criminal statute of the state of Tennessee. TENN. CODE ANN. § 63-6-214(b)(2). To-wit: the commission of a Class C felony, punishable by three (3) to fifteen (15) years imprisonment and a fine of up to $10,000.00. *See* TENN. CODE ANN. § 39-16-503(a)(2).

38. The Board concludes that the facts contained in ¶¶ 5(a)(b) constitute acts or omissions which would constitute grounds for discipline of a person licensed in Tennessee. Specifically, the Board concludes that such acts or omissions would constitute the violation or attempted violation, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any criminal statute of the state of Tennessee. TENN. CODE ANN. § 63-6-214(b)(2). To-wit: the commission of a Class C misdemeanor (TENN. CODE ANN. § 39-13-606, Electronic Tracking of Motor Vehicles), punishable by up to thirty (30) days in jail or a fine of up to $50.00 or both. *See* TENN. CODE ANN. § 39-13-606.

39. The Board concludes that the facts contained in ¶¶ 2(a)(b)(c)(d), 3(a)(b)(c)(d)(e)(f)(g), 7(a)(b)(c)(d), 8(a)(b)(c)(d)(e), 10(a)(b)(c)(d)(e)(f), 12(a)(b)(c), 13(a)(b)(c), 14(a)(b)(c), 15(a)(b)(c)(d)(e)(f)(g)(h), 18, 20, 22(a)(c), and 23(a)(b) constitute a pattern of continued or repeated negligence and incompetence.

40. The Board concludes that the facts contained in ¶¶ 4, 6, 16, 19, and 21 do not constitute violations of the TENN. CODE ANN. §§ 63-6-101 *et seq*.

ORDER

THEREFORE, in consideration of the above Findings of Fact and Conclusions of Law, it is **ORDERED** that:

41. Respondent's license to practice medicine is hereby PERMANENTLY REVOKED.

42. The respondent is assessed eight (8) Type A civil penalties in the amount of One Thousand Dollars ($1,000) each for a total of Eight Thousand Dollars ($8,000). **Said penalty is due and payable to the Board of Medical Examiners, in certified funds or**

money order, c/o Disciplinary Coordinator, 1st Floor Cordell Hull Building, 425 5th Avenue North, Nashville, Tennessee 37247.

43. The respondent must pay the actual and reasonable costs of prosecuting this case to the extent allowed by law. TENN. CODE ANN. § 63-6-214(k). These costs will be established by an Affidavit of Costs prepared and filed by counsel for the Department. Costs shall be paid by submitting a **certified check, cashier's check, or money order** payable to the State of Tennessee, which shall be mailed or delivered to: **Disciplinary Coordinator, The Division of Health Related Boards, Tennessee Department of Health, 3rd Floor, Cordell Hull Building, 425 5th Avenue North, Nashville, Tennessee 37247.** A notation shall be placed on said check that it is payable for the costs of Charles Harlan, M.D., Docket Number 17.18-022307A.

POLICY REASONS FOR DECISION

This action was taken by the Board of Medical Examiners in order to protect the health, safety and welfare of the citizens of the State of Tennessee.

Signed this _____ day of _____, 2005.

_____
Sam Barnes, M.D.
Panel Chairperson
Tennessee Board of Medical Examiners

RECONSIDERATION, ADMINISTRATIVE RELIEF AND JUDICIAL REVIEW

Within fifteen (15) days after the entry of an initial or final order, a party may file a petition to the Board for reconsideration of the Final Order. If no action is taken within twenty (20) days of filing of the petition with the Board, it is deemed denied. TENN. CODE ANN. § 4-5-317 (Supp. 2002).

In addition, a party may petition the Board for a stay of the Final Order within seven (7) days after the effective date of the Final Order. TENN. CODE ANN. § 4-5-316 (1998).

Finally, a party may seek judicial review by filing a petition for review in the Chancery Court of Davidson County within sixty (60) days after the effective date of the Final Order. A petition for reconsideration does not act to extend the sixty (60) day period; however, if the petition is granted, then the sixty (60) day period is tolled and a new sixty (60) day period commences from the effective date of the Final Order disposing of the petition. TENN. CODE ANN. § 4-5-322 (Supp. 2002).

Prepared for entry:

Laurie Lea Doty, B.P.R. #12404
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CERTIFICATE OF FILING

This Order was received for filing in the Office of the Tennessee Secretary of State, Administrative Procedures Division, and became effective on the _____ day of _____, 2005.

_____

Charles C. Sullivan, II, Director
Administrative Procedures Division

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document as yet unsigned has been served upon the Respondent's attorney: Daniel Warlick, Esquire, by facsimile, 615-254-0011, on this 29th day of April, 2005, and a true and correct copy of this document as entered has been served upon the Respondent's attorney: Daniel Warlick, Esquire, 611 Commerce Street, Suite 2712, The Tower, Nashville, Tennessee 37203, by delivering the same via the United States Mail, Certified _____, return receipt requested, with sufficient postage thereon to reach its destination.

This _____ day of _____, 2005.

_____

Laurie Lea Doty, B.P.R. #12404
Deputy General Counsel