

IN THE SUPREME COURT OF MISSOURI

Case No. SC89809

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,

Appellant,

v.

FAISAL J. ALBANNA, M.D.,

Respondent.

Transfer from the Missouri Court of Appeals, Western District

Case No. WD67905

**APPELLANT STATE BOARD OF REGISTRATION
FOR THE HEALING ART'S SUBSTITUTE BRIEF**

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JURISDICTIONAL STATEMENT

This appeal is from a decision made by the State Board of Registration for the Healing Arts (the “Board”) disciplining Dr. Albanna’s medical license based on Findings of Fact and Conclusions of Law of the Missouri Administrative Hearing Commission (“AHC”). The Board’s order was reversed on Dr. Albanna’s *Petition for Judicial Review* under Chapter 536, RSMo, by the Nineteenth Judicial Circuit, Circuit Court of Cole County, Missouri.¹ The case was then appealed to the Western District Court of Appeals, who affirmed the AHC’s decision finding “conduct that might be harmful to a patient”, “conduct harmful to the patient,” and “repeated negligence” as it pertained to patients C.W. and S.W. The Western District Court of Appeals reversed the AHC’s findings of “unprofessional conduct” and “incompetency,” and remanded the case to the Board for reconsideration of its discipline based on the Court’s findings.

The case was then transferred to the Missouri Supreme Court, which has jurisdiction pursuant to MO. CONST. Art V., § 10 and Rule 83.04. At any stage of judicial review, the court reviews the decision of the agency and not the judgment of the lower court. *Morton v. Brenner*, 842 S.W.2d 538, 540 (Mo. banc 1992); *Psychcare Mgt. v. Dept. of Social Services*, 980 S.W.2d 311, 312 (Mo. banc 1998).

¹ All references to Missouri Statutes are to the Revised Statutes of Missouri, 2000, unless otherwise noted.

STATEMENT OF FACTS

The Administrative Hearing Commission (“AHC”) found that Dr. Albanna’s medical license was subject to discipline under Counts II and IV of the Board’s *First Amended Complaint* based on violations of the provisions of Section 334.100.2, RSMo. (L.F. 6). The AHC found that there was no cause for disciplining Dr. Albanna’s medical license under the other four counts alleged in the Board’s *First Amended Complaint*. Dr. Albanna’s treatment of patient S.W. in Count II was adjudged to be unprofessional conduct and conduct that might have been harmful to the patient. (L.F. 6, 57).

Additionally, the AHC found that Dr. Albanna’s conduct in performing an inappropriate operation on patient S.W. was negligent. (L.F. 57). Dr. Albanna’s treatment of patient C.W. in Count VI was found to be incompetent, unprofessional, and conduct that was or might have been harmful to the patient. (L.F. 6, 71, 73, 80). The AHC further found that Dr. Albanna was negligent in respect to the treatment of patient C.W. in that he failed to differentiate between muscular and disk pain before surgery, in that he performed a fusion surgery instead of a simpler discectomy operation, in that he failed to inform C.W. that there were less intrusive surgical options available, in that he failed to get C.W.’s informed consent for using Pro-Osteon in an off-label manner, in that he used a surgical technique that destabilized C.W.’s spine and contributed to the failure of his fusion, in that he failed to recognize and correct the destabilized spine after surgery, in that he failed to document the full extent of the surgery in his operative notes, and in that he falsely reported a good fusion when imaging showed that a fusion was not occurring. (L.F. 68-80).

The Board's experts Dr. Smith and Dr. Freeman both testified that they are board certified neurosurgeons who currently practiced neurosurgery. (L.F., AHC Tr., Vol. I, 36:22-38:6; Board's Supp. L.F. 5:2-6:18). Dr. Smith has practiced neurosurgery since 1975. (L.F., AHC. Tr., Vol. I, 36:3-21). Dr. Freeman not only has practiced neurosurgery since 1988, but he is a professor of neurosurgery at the University of South Florida. (Board's Supp. L.F. 5:4-16). Both Dr. Smith and Dr. Freeman possess education and knowledge about the field of neurosurgery, and are therefore qualified to give expert testimony.

Patient S.W.

Dr. Albanna first saw patient S.W. in 1996 with neck problems and pain (L.F., AHC Tr., Vol. IV, 1128:6-19). Dr. Albanna ordered several tests to determine the cause of patient S.W.'s pain, including a myelogram, post myelogram computerized tomography scan, and an MRI. (L.F., AHC Tr., Vol. I, 42:1-22). Dr. Beal, a radiologist, reported the findings of the radiographic tests, and noted "no evidence of disc herniation, central spinal stenosis or cord compression." (L.F., AHC Tr., Vol. I, 44:21-45:16). Dr. Beal found no significant abnormality. (L.F., AHC Tr., Vol. IV, 1136:4-10). The Board's expert Dr. Smith stated that his review of the myelogram differed from Dr. Beal's, but only in that he found mild bilateral foraminal narrowing at level C3-C4. (L.F., AHC Tr., Vol. I, 47:7-48:7). Dr. Albanna's stated interpretation of the imaging differed from both Dr. Beal's and Dr. Smith's, in that Dr. Albanna claimed that the myelogram indicated

spinal stenosis at levels C3 through C7. (L.F., AHC Tr., Vol. IV, 1132:13-16; L.F., AHC Tr., Vol. I, 69:1-23).

Dr. Albanna performed a posterior decompressive cervical laminectomy, a foraminotomy at levels C3-C4-C5-C6-C7, and a fusion on patient S.W. on November 13, 1996. (L.F., AHC Tr., Vol. I, 84:1-10). On November 15, 1996, S.W. experienced central cord syndrome, which is damage to the nerve tissue within the spinal cord serious enough to cause “dysfunction in the strength and sensation in the upper extremities.” (L.F., AHC Tr., Vol. I, 84:9-85:19; L.F., AHC Tr., Vol. IV, 1140:25-1141:20). S.W. did not respond to stimulation and had only a faint pulse. (L.F. 20). Central cord syndrome is generally caused by a flexion injury such as may result from surgical destabilization of the spine. (L.F., AHC Tr., Vol. I, 85:1-23).

The AHC found that Drs. Catherine Beal, Greg Bailey, and Melissa Neiman all agreed that there was nothing in the imaging that indicated surgery was necessary for patient S.W. (L.F. 54). Dr. Smith also testified that the surgery that Dr. Albanna performed on S.W. was unwarranted. (L.F., AHC Tr., Vol. I, 81:24-82:6). Dr. Smith described the additional risks of performing the four-level laminectomy as opposed to a one-level as:

“(1) a longer operation, (2) more blood loss, (3) more chance of spinal cord and nerve injury, (4) higher incidence of and more extensive epidural scarring, (5) more postoperative pain, (6) longer recovery period, (7) prolonged immobilization while waiting for fusion, (8) much more

limitation of movement, (9) forces normally acting at C3-4 are transmitted to C2-3, leading to failure as C2-3.”

(L.F., AHC Tr., Vol. I, 87:16-88:12).

The AHC found that Dr. Albanna performed an inappropriate operation on patient S.W., in that there was not sufficient evidence to warrant the surgery that was performed. (L.F. 57). The AHC found that Dr. Albanna’s actions constituted negligence, unprofessional conduct, and conduct that might be harmful to the patient. (L.F. 57). The AHC found that Dr. Albanna’s medical license was subject to discipline for unprofessional conduct and conduct that might be harmful to the patient for his treatment of patient S.W., as required by Section 334.100.2(5), RSMo. (L.F. at 57).

Patient C.W.

Patient C.W. first presented to Dr. Albanna in 1998, after experiencing a work related injury. (L.F., AHC Tr., Vol. IV, 1097:1-11). Patient C.W. was experiencing pain in his lower back and down both of his legs. (L.F., AHC Tr., Vol. IV, 1097:8-22). Dr. Albanna initially recommended that patient C.W. undergo a “bilateral lumbar microlaminectomy, microdiskectomy L4-L5, and posterior lumbar interbody fusion.” (L.F., AHC Tr., Vol. IV, 1146:17-23). The Board’s expert, Dr. Freeman testified that most people that suffer from back pain suffer from muscular pain, and that Dr. Albanna failed to adequately differentiate patient C.W.’s back pain before performing surgery on him. (Board’s Supp. L.F., 15:11-17:22). Dr. Freeman stated that after looking at the

MRI's of patient C.W.'s spine, there was nothing on the MRI that would lead to back pain that would benefit from a fusion surgery. (Board's Supp. L.F., 26:17-20). The AHC examined the testimony of the experts in the case, and accepted Dr. Freeman's testimony that a simple discectomy was the proper procedure given the circumstances in evidence. (L.F. 73). Even Dr. Albanna's own expert Dr. Wilkinson testified that he would not have performed a fusion, but instead would have performed a simple discectomy. (L.F., AHC Tr., Vol. II, 560:16-20). The AHC found that Dr. Albanna performed a more extensive operation than was needed, which was conduct that was harmful to the patient. (L.F. 73).

Dr. Freeman also testified that during the fusion surgery, Dr. Albanna's placement of the first Ray cage was off center, which caused Dr. Albanna to destabilize the spine in order to place the second Ray cage. (Board's Supp. L.F., 28:3-30:19). According to Dr. Freeman, Dr. Albanna failed to recognize his mistake and correct it. (Board's Supp. L.F., 34:17-35:8, 42:3-7). Dr. Freeman also testified that the misplaced Ray cages began pushing on the nerves in C.W.'s spinal canal, causing him to experience burning pain. (Board's Supp. L.F., 36:22-37:14). The evidence presented was that Dr. Albanna's conduct resulted in C.W. experiencing burning pain.

Dr. Albanna used a coral substitute called Pro-Osteon to effectuate the fusion. (L.F., AHC Tr., Vol. IV, 1121:21-1122:17). Dr. Freeman testified that Pro-Osteon was not FDA approved for spine use in 1998, when Dr. Albanna used the substance on patient C.W. (Board's Supp. L.F., 33:10-34:15). The standard of care for using Pro-Osteon in an off-label manner requires the surgeon to secure the patient's informed consent, which was not done in this instance. (Board's Supp. L.F., 41:15, 54:12-55:2).

The AHC also found Dr. Freeman's testimony credible that Dr. Albanna did not inform patient C.W. of any other alternatives to the surgery that he performed. (Board's Supp. L.F., 53:3-20). Patient C.W. testified at the hearing that Dr. Albanna did not discuss any other surgical options with him. (L.F., AHC Tr., Vol. II, 368:24-370:6). Patient C.W.'s wife was present when he discussed the upcoming surgery with Dr. Albanna and confirmed that Dr. Albanna did not offer any surgical alternatives. (L.F., AHC Tr., Vol. II, 414:25-417:4). Both Dr. Freeman and Dr. Wilkinson agreed that the standard of care required Dr. Albanna to advise patient C.W. of the primary surgical options. (Board's Supp. L.F., 52:17-53:7; L.F., AHC Tr., Vol. II, 581:5-13). Dr. Albanna himself testified that the standard of care required him to explain the pros and cons of the surgery he did and at least a discectomy or microdiscectomy. (L.F., AHC Tr., Vol. IV, 1147:20-1148:17)

Following the surgery C.W. complained of lower back pain and leg pain, and he eventually sought treatment from Dr. David R. Lange. (Board's Supp. L.F., 37:15-20). The AHC found that Dr. Albanna had falsely reported that a fusion was taking place, when in fact even Dr. Albanna's own experts testified that no fusion was taking place. (L.F., AHC Tr., Vol. II, 590:10-593:1). The AHC found that Dr. Albanna stated in his medical notes on November 7, 1998, that patient C.W.'s spine was fusing, even though Dr. Albanna's own expert Dr. Raskas testified that as of July 14, 1998, the left cage had begun moving. (L.F. 79). The fusion ultimately failed, causing patient C.W. pain, and on March 6, 1999, Dr. Lange removed the left Ray cage from C.W.'s spine and performed and interbody fusion and lateral fusion. (Board's Supp. L.F., 37:15-23). In the process of

removing the cage, Dr. Lange moved the nerves in C.W.'s spine, which resulted in more damage to the nerves. (Board's Supp. L.F., 37:22-38:9).

The AHC also held that Dr. Albanna's medical license was subject to discipline for repeated negligence, unprofessional conduct, conduct that was of might have been harmful to the patient, and incompetence for his treatment of patient C.W., in accordance with Section 334.100.2, RSMo. (L.F. 80).

Board Discipline

After the AHC independently found cause to discipline Dr. Albanna's medical license, the Board placed Dr. Albanna's license on probation for a period of five (5) years. The Board placed some narrowly tailored restrictions on Dr. Albanna's license during the probationary period which were designed to address the AHC's findings, and to protect the public from the exact type of conduct that the AHC found Dr. Albanna had engaged in. The AHC found that Dr. Albanna "over-diagnosed and over-treated" certain patients. (L.F. 80).

The Board's disciplinary order required that before Dr. Albanna could perform spinal surgery on patients involving fusions and/or instrumentation, the patients must obtain a second opinion from a Board certified neurosurgeon. Also the disciplinary order required patients of Dr. Albanna to sign a Board-mandated form of informed consent, but again, this was only for patients who Dr. Albanna was going to perform spinal surgeries involving fusions and/or the use of instrumentation.

Procedure

The AHC found cause to discipline Dr. Albanna's medical license after conducting a full hearing. After the Board imposed discipline on Dr. Albanna, Dr. Albanna appealed the decision to the Circuit Court of Cole County. The Circuit Court reversed the Board and the AHC, and the Board appealed to the Western District Court of Appeals. The Western District affirmed the AHC's decision that there was cause to discipline Dr. Albanna's medical license for his treatment of patients S.W. and C.W. The Western District held that the AHC had properly found that Dr. Albanna was guilty of repeated negligence for his treatment of patients S.W. and C.W., and also that his treatment of both patients constituted conduct that was or might be harmful to the patient. (Slip Opinion, 20).

Dr. Albanna requested transfer to this Court, which was granted on February 24, 2009.

POINTS RELIED ON

I.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA IS SUBJECT TO DISCIPLINE FOR UNPROFESIONAL CONDUCT BECAUSE IT CORRECTLY APPLIED THE LAW IN THAT THERE WAS SUBSTANTIAL AND COMPETENT EVIDENCE TO SUPPORT A FINDING THAT DR. ALBANNA'S CONDUCT BREACHED PROFESSIONAL STANDARDS BASED ON COMMON OPINION AND FAIR JUDGMENT.

Perez v. State Bd. of Registration for the Healing Arts, 803 S.W.2d 160 (Mo. App. 1991).

Hughes v. State Bd. of Health, 159 S.W.2d 277 (Mo. 1942).

Lentine v. State Bd. of Health, 65 S.W.2d 943 (Mo. 1933).

Section 334.100.2(4), RSMo

II.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA IS SUBJECT TO DISCIPLINE FOR REPEATED NEGLIGENCE BECAUSE IT USED THE CORRECT APPLICATION OF THE LAW AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE IN THAT

A.

THE AHC APPLIED THE PROPER LEGAL STANDARD FOR MEDICAL NEGLIGENCE

B.

REPEATED NEGLIGENCE IS DEFINED BY THE STATUTE, AND DOES NOT REQUIRE A HEIGHTENED FINDING OR A GROSS DEPARTURE FROM THE APPROPRIATE STANDARD OF CARE

C.

THE FINDINGS MADE BY THE AHC ARE SUPPORTED BY EVIDENCE IN THE RECORD, AND THE REASONABLE MEDICAL JUDGEMENT RULE DOES NOT APPLY TO THIS CASE SINCE EXPERT TESTIMONY WAS PRESENTED THAT SUPPORTED THE AHC'S FINDING THAT DR. ALBANNA WAS NEGLIGENT IN HIS TREATMENT OF S.W. AND C.W.

Haase v. Garfinkel, 418 S.W.2d 108 (Mo. 1967)

Section 324.043.3, RSMo

Section 334.100.2(5), RSMo

III.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA ENGAGED IN CONDUCT THAT IS OR MIGHT BE HARMFUL OR DANGEROUS TO A PATIENT BECAUSE ITS HOLDING WAS CORRECTLY BASED ON THE PROPER APPLICATION OF THE LAW IN THAT THERE IS NOT A HEIGHTENED REQUIREMENT THAT THE ONLY CONDUCT THAT CAN BE SANCTIONED BY THE BOARD TO PROTECT THE PUBLIC MUST BE AKIN TO QUACKERY, AND THERE WAS COMPETENT AND SUBSTANTIAL EVIDENCE THAT DR. ALBANNA'S CONDUCT CAUSED OR MIGHT HAVE CAUSED HARM TO PATIENTS S.W. AND C.W.

Moheet v. State Bd. of Registration for the Healing Arts, 154 S.W.3d 393

(Mo. App. 2004).

Tendai v. State Bd. of Registration for the Healing Arts, 161 S.W.3d 358

(Mo. banc 2005).

Section 334.100.2(5), RSMo

IV.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA WAS INCOMPETENT BECAUSE SUCH HOLDING WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE, AND IS CONSISTENT WITH A FINDING OF GENERAL LACK OF, OR LACK OF DISPOSITION TO USE, A PROFESSIONAL ABILITY

Section 334.100.2(5), RSMo

V.

THE BOARD DID NOT ERR IN ITS IMPOSITION OF DISCIPLINE BECAUSE PLACING DR. ALBANNA'S LICENSE ON A PROBATIONARY PERIOD WAS FAIR AND AUTHORIZED BY LAW, IN THAT THE DISCIPLINE WAS JUSTIFIED BY STATUTORY AUTHORITY, WAS REQUIRED TO PROTECT THE PUBLIC, WAS NOT DISCRIMINATORY, AND WAS THE RESULT OF A FAIR AND IMPARTIAL HEARING.

Artman v. State Bd. of Registration for the Healing Arts, 918 S.W.2d 247

(Mo. banc. 1996).

Burgdorf v. Bd. of Police Comm'rs, 936 S.W.2d 227 (Mo. App. E.D. 1996).

Marler v. Mo. State Bd. of Optometry, 102 F.3d 1453 (8th Cir. 1996).

State Bd. of Registration for the Healing Arts v. Brown, 121 S.W.3d 234

(Mo. banc. 2003).

4 C.S.R. 150-7.140(3) (2000).

ARGUMENT

I.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA IS SUBJECT TO DISCIPLINE FOR UNPROFESIONAL CONDUCT BECAUSE IT CORRECTLY APPLIED THE LAW IN THAT THERE WAS SUBSTANTIAL AND COMPETENT EVIDENCE TO SUPPORT A FINDING THAT DR. ALBANNA'S CONDUCT BREACHED PROFESSIONAL STANDARDS BASED ON COMMON OPINION AND FAIR JUDGMENT.

Standard of Review

Judicial review of the orders of the AHC is authorized under the provisions of Sections 621.145, RSMo, as well as Sections 536.100 through 536.150, RSMo. The order and decision of the AHC in this case, as represented by its Findings of Fact and Conclusions of Law, entered on December 27, 2004, may be reviewed and challenged only if the agency action:

- (A) is in excess of statutory authority and/or jurisdiction of the Commission;
- (B) is unsupported by competent and substantial evidence upon the whole record;
- (C) is unauthorized by law;
- (D) is arbitrary, capricious and unreasonable;
- (E) involves abuse of discretion;

(F) erroneously announces and applies Missouri law; and therefore is reviewable by this Court under the provisions of Section 621.145, RSMo, and Section 536.140, RSMo.

In an appeal from an administrative appeal, the courts review the decision of the administrative agency rather than the circuit court. *Psychcare Mgt. v. Dept of Social Services*, 90 S.W.2d 311, 312 (Mo. banc 1998). In Missouri, an appellant court's review of an administrative decision is clearly defined, and limited in scope. The AHC decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo. Upon review in a physician licensure proceeding, decisions by the AHC are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W.2d 894, 900 (Mo. App. 1997). The agency's findings of fact are given great deference as the fact-finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo. App. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. 1981)).

This Court has stated that appellate courts must look at the entire record in reviewing an agency's decision. *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004). The appellate court should not redetermine the issues on appeal, but should look at the entire record to determine whether there is competent and substantial evidence to support the agency's findings. *Id.*

Argument

The AHC found Dr. Albanna's medical license was subject to discipline under Section 334.100.2(4), RSMo, for unprofessional conduct. (L.F. 57). More specifically, the AHC found that Dr. Albanna performed a four-level laminectomy and a lateral mass fusion on patient S.W., and that there was "insufficient evidence to warrant the very extensive operation that he performed." (L.F. 57). The AHC Decision was based on testimony from the Board's expert, Dr. Smith, a board certified neurosurgeon who stated that Dr. Albanna performed a "radical, unwarranted operation." (L.F., AHC Tr., Vol. I, 70:25-71:2). Dr. Smith reviewed the evidence in the record, and noted that Dr. Albanna's choice of surgery was a laminectomy and lateral mass fusion, which Dr. Smith felt "grossly" violated the standard of care. (L.F., AHC Tr., Vol. I, 81:20-82:6). Dr. Smith further stated that there was no indication of spinal cord compression in the medical record, and absent spinal cord compression there is no reason to perform a laminectomy. (L.F., AHC Tr., Vol. I, 83:3-22). Dr. Smith stated that based on the imaging and Dr. Albanna's medical records, either an anterior cervical discectomy or a bilateral foraminotomy would have been appropriate operations for patient S.W. (L.F., AHC Tr., Vol. I, 82:7-25).

Dr. Smith further testified that the surgery that Dr. Albanna performed offered increased risks to patient S.W., which included such things as more blood loss, more chance of spinal cord and nerve injury, higher risk of scarring, more pain, longer recovery time, longer immobilization, limited movement, and the surgery causes more weight to be transferred to the levels above and below the fusion, which can lead to

failure at this levels. (L.F., AHC. Tr., Vol. I, 87:16-88:12). Dr. Albanna's own expert Dr. Lichtor stated that based on the medical record he would have recommended a foraminotomy, not the surgery Dr. Albanna performed. (L.F., AHC Tr., Vol. II, 306:22-307:9).

The AHC stated that unprofessional conduct includes "conduct which by common opinion and fair judgment is determined to be unprofessional or dishonorable." (L.F. 50)(citing *Perez v. State Bd. of Registration for the Healing Arts*, 803 S.W.2d 160, 164 (Mo. App. W.D. 1991)). Taking its plain meaning, unprofessional conduct is defined as "conduct that does not conform to the technical or ethical standards of the profession." MERRIAM-WEBSTER'S COLLEGE DICTIONARY 930 (10th ed. 1993). While the definition of unprofessional conduct may not be specifically enumerated in the statute itself, Missouri cases have clearly established that unprofessional conduct may be a cause for disciplining a physician's license. In this case it is clear from the evidence that Dr. Albanna had no medical basis to perform the extensive and risky surgery on patient S.W. Dr. Albanna argues that the definition that the AHC used is not adequate, but other Missouri courts have used the same definition in their rulings. *See Perez*, 803 S.W.2d at 164; *Hughes v. State Bd. of Health*, 159 S.W.2d 277, 278 (Mo. 1942); *Lentine v. State Bd. of Health*, 65 S.W.2d 943, 948 (Mo. 1933).

In the *Lentine* case, this Court specifically discussed the fact that they felt "constrained to hold that the use of the general terms 'bad moral character' and 'unprofessional and dishonorable conduct' in specifying the grounds for revocation of a physician's license does not render our statute too uncertain, vague or ambiguous as to be

unenforceable.” *Lentine*, 65 S.W.2d at 949. This Court has stated that “it is a wholesome and well-recognized rule of law that powers conferred upon boards of health to enable them to perform their important functions in safeguarding the public health should receive liberal construction.” *Id.* at 950. While Dr. Albanna is correct that both the *Hughes* and the *Lentine* cases were decided before the Legislature created the AHC to decide these types of licensing cases, the basic ideas still apply. The Missouri Legislature re-introduced the term “unprofessional conduct” to Section 334.100.2(4) in 1987, knowing that the procedure for deciding these cases had changed with the creation of the AHC. The Legislature did not add additional constraints to the term upon reintroducing it to Section 344.100.2(4), knowing that the term had been defined previously in Missouri Law. *See Wollard v. Kansas City*, 831 S.W.2d 200, 203 (Mo. banc 1992)(discussing the fact that the Legislature is presumed to know the law, and when amending a law the words are meant to be construed by their plain and ordinary meaning). Had the Legislature wanted the term to take on a new meaning, the Legislature could have done so by defining the term in a new manner in the statute itself.

Dr. Albanna argues that the AHC should have narrowed the definition of unprofessional conduct to only include instances where “a showing of bad motive and intent” are found. This narrow reading of the statute’s requirements is categorically wrong, and would require a finding that extends beyond what the Legislature intended for disciplining a physician for unprofessional conduct. Such a heightened requirement would not only limit the Board’s powers in protecting the public, but it grossly misreads the statute itself.

By adding the requirement of a bad motive or intent, Dr. Albanna ignores many of the other subsections under 334.100.2(4) that do not require such a finding. When the non-exhaustive list of causes for discipline that fall under 334.100.2(4) is examined, there are several subsections that do not require either bad intent or motive. Such examples include failing to timely pay license renewal fees, delegating professional responsibilities to a person who is not qualified to perform such responsibilities, and failing to inform the board of the physician's current residence and business address. Section 334.100.2(4)(d), (n), (p), RSMo. The inclusion of these subsections into 334.100.2(4) cuts against Dr. Albanna's claim that the Legislature requires a finding of bad motive or intent for a finding of unprofessional conduct to be actionable.

Despite Dr. Albanna's claim to the contrary, Missouri case law dictates that the AHC is qualified to gauge whether a licensee's conduct is unprofessional. The court in the *Perez* case held that expert testimony was not needed in order to allow "inexperienced persons" to decide whether Dr. Perez had engaged in unprofessional conduct. *Perez*, 803 S.W.2d at 164. As in this case, "the facts presented herein were sufficient" to allow the *Perez* court to make such a decision that the conduct was unprofessional. *Id.* In this case, direct testimony established that Dr. Albanna performed extensive surgery on a patient when it was not medically indicated. Dr. Albanna is arguing that the Board needed to have an expert testify that performing extensive surgery on a patient when it is not indicated is "unprofessional," when in fact the evidence itself allows the AHC to make the legal judgment "by common opinion and fair judgment" that the conduct fails to conform to the technical or ethical standards of Dr. Albanna's profession.

Dr. Albanna also points to the fact that several of the reported cases where the Board has disciplined physicians for unprofessional conduct are instances where the physicians have been guilty of felonies, sexual relationships with patients, and assaults. While the cases that have been cited by Dr. Albanna do include such examples of unprofessional acts, none of the examples are similar to Dr. Albanna's case in that they do not adequately represent the same type of conduct. The fact remains that the statute allows the Board to discipline physicians whose action "by common opinion and fair judgment is determined to be unprofessional or dishonorable." (L.F. 50)(citing *Perez*, 159 S.W.2d at 164). Much like the *Perez* case, the AHC did not need expert testimony to state that a physician who performed a radical, unwarranted surgery on a patient engaged in unprofessional conduct. Furthermore, requiring an expert to testify that Dr. Albanna has acted unprofessionally is akin to him making a legal conclusion, and the AHC is in a better position to make that call, especially when "common opinion and fair judgment" are to be the basis for the finding. Due to the fact that there is direct testimony establishing that Dr. Albanna performed a risky, unwarranted surgery on patient S.W. when S.W. did not need such a surgery, the AHC correctly found that Dr. Albanna's medical license was subject to discipline for unprofessional conduct.

II.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA IS SUBJECT TO DISCIPLINE FOR REPEATED NEGLIGENCE BECAUSE IT USED THE CORRECT APPLICATION OF THE LAW AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE IN THAT

Standard of Review

Judicial review of the orders of the AHC is authorized under the provisions of Sections 621.145, RSMo, as well as Sections 536.100 through 536.150, RSMo. The order and decision of the AHC in this case, as represented by its Findings of Fact and Conclusions of Law, entered on December 27, 2004, may be reviewed and challenged only if the agency action:

- (A) is in excess of statutory authority and/or jurisdiction of the Commission;
- (B) is unsupported by competent and substantial evidence upon the whole record;
- (C) is unauthorized by law;
- (D) is arbitrary, capricious and unreasonable;
- (E) involves abuse of discretion;
- (F) erroneously announces and applies Missouri law; and therefore is reviewable by this Court under the provisions of Section 621.145, RSMo, and Section 536.140, RSMo.

In an appeal from an administrative appeal, the courts must review the decision of the administrative agency rather than the circuit court. *Psychcare Mgt. v. Dept of Social Services*, 90 S.W.2d 311, 312 (Mo. banc 1998). In Missouri, an appellate court's review of an administrative decision is clearly defined, and limited in scope. The AHC decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo. Upon review in a physician licensure proceeding, decisions by the AHC are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W.2d 894, 900 (Mo. App. 1997). The agency's findings of fact are given great deference as the fact-finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo. App. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. 1981)).

This Court has stated that appellate courts must look at the entire record in reviewing an agency's decision. *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004). The appellate court should not redetermine the issues on appeal, but should look at the entire record to determine whether there is competent and substantial evidence to support the agency's findings. *Id.*

Argument

A.

THE AHC APPLIED THE PROPER LEGAL STANDARD FOR MEDICAL NEGLIGENCE

Dr. Albanna failed to raise a medical judgment rule argument in his *Petition for Judicial Review* in the Circuit Court of Cole County. By not raising the issue in the original petition, the substance of this point-relied-on and this legal point was not preserved for review.² *Chipperfield v. Mo. Air Conservation Comm'n*, 229 S.W.3d 226, at fnt. 10, 2007 Mo. App. LEXIS 892 (Mo. App. S.D. June 18, 2007); *Edwards v. Mo. State Bd. of Chiropractic Exam'rs*, 85 S.W.3d 10, 21 (Mo. App. W.D. 2002); *Ruffin v. City of Clinton*, 849 S.W.2d 108, 114 (Mo. App. W.D. 1993).

Regardless of the fact that Dr. Albanna has waived to his right to argue this issue, his reliance on the so-called medical judgment rule is misplaced. Dr. Albanna argues that “[a]s long as there is room for an honest difference of opinion among competent physicians, a physician who uses his own best judgment cannot be convicted of negligence, even though it may afterward develop that he was mistaken.” *Haase v. Garfinkel*, 418 S.W.2d 108 (Mo. 1967). The difference is that in the *Haase* case, the evidence demonstrated a “strong dichotomy in the medical profession” on using certain anticoagulating drugs. *Id.* at 114. This court stated in the *Haase* case that “the “record

² *The Petition for Judicial Review* is found at page 1 of the Record on Appeal. A copy of *the Petition for Judicial Review* is included in the Appendix for ready reference.

reveals no evidence that defendant's conduct ran counter to the course of treatment recognized by the profession generally." *Id.* In the present case, there is direct testimony to support the AHC's findings that Dr. Albanna violated the standard of care, and was therefore negligent.

Furthermore, there are several findings that the AHC made regarding violations of the standard of care that cannot be considered honest differences of opinion. An example is the issue of not properly getting a patient's informed consent, which is clearly defined by law. Dr. Albanna had a duty to inform both S.W. and C.W. that there were alternatives to the surgery that he performed, and he clearly did not do so. Dr. Albanna's expert Dr. Wilkinson stated that the standard of care required Dr. Albanna to outline the basic options of surgery, and in the case of C.W., there were several options. (L.F., AHC Tr., Vol. II, 581:10-13). The evidence presented was that Dr. Albanna failed to offer C.W. any alternatives to the surgery he performed, not even the microdiscectomy that his own expert would have recommended. This is not a question of medical judgment at all, and the same applies to Dr. Albanna failing to get informed consent for using Pro-Osteon on C.W., as well as the finding that he falsely reported a fusion occurring and failed to properly record operative notes.

Dr. Albanna's argument is essentially that any time a physician can find any expert who states that the physician did not violate the standard of care, then there is a "difference of opinion" within the medical profession, and the physician can never be found guilty of negligence. This argument runs contrary to Missouri law and in the sense

of Board disciplinary cases, this view frustrates the ability of the Board to protect the public. In the case of patient C.W., Dr. Freeman testified:

Q. Are we in an area here of medical judgment, or would the standard of care speak to this issue?

A. The issue for fusion is a medical judgment issue that I think the community in general would say that this was way over the line.”

(Board’s Supp. Brief, 108:11-15)

Dr. Albanna presented two experts who stated that they were “conservative” surgeons who testified that they would not have chosen the same surgery that Dr. Albanna performed. Dr. Lichtor testified that he would not have performed the laminectomy and fusion that Dr. Albanna performed on patient S.W. because he is “just sort of a conservative person” who “would say most of the pain is due to the foraminal stenosis in the case and that a simple operation is just to drill out the neural foramen.” (L.F., AHC Tr., Vol. II, 314:16-315:5). Dr. Lichtor stressed that his approach is a conservative approach.

Dr. Wilkinson testified that he would not have chosen the surgery that Dr. Albanna performed on patient C.W., stating that he would instead have performed a microdiscectomy instead of going with a fusion. (L.F., AHC Tr., Vol. II, 560:18-20). Again, Dr. Wilkinson stated that his “philosophy is to do the minimal amount to get the root decompressed and hopefully get the patient back to work.” (L.F., AHC Tr., Vol. II, 560:20-23). Dr. Wilkinson further testified:

Q. Do you believe a fair number of surgeons would have done the fusion rather than the procedure you were talking about or do you have any basis?

A. I can't answer that. I don't know that answer. I have to tell you what I would do."

(L.F., AHC Tr., Vol. II, 561:6-10).

Dr. Wilkinson's testimony does not even focus on what a reasonable physician would do, but only references his own choice, which is not the surgery that Dr. Albanna performed. The AHC correctly pointed out that Dr. Wilkinson's testimony "does not support Albanna's position that his decision to perform a fusion in this case was 'consistent with the degree of skill and learning ordinarily used under the same or similar circumstances' by another neurosurgeon." (L.F. 73). Dr. Albanna did provide one expert who did testify that he would have chosen to do the fusion in this case, but the AHC, as the fact finder, found "Freeman's testimony on this point more convincing" and found that Dr. Albanna's choice of surgery was a violation of the standard of care. (L.F. 73). Again, the AHC's decision as the fact finder on this case should be preserved, especially due to the fact that there was competent and substantial evidence presented by the Board that this choice of surgery was excessive and inappropriate.

Dr. Albanna also argues that repeated negligence should not be found in this case due to the fact that the two findings made by the AHC are isolated, and occurred at different times. His argument is again not supported by the statute and is not supported by Missouri law. In fact, repeated negligence is exempt from a statute of limitations in

Missouri, indicating that Dr. Albanna's argument that the findings of negligence must somehow occur within a set amount of time is incorrect. Section 324.043.4, RSMo. The legislature did not limit the time frame on repeated negligence, and the findings made by the AHC for repeated negligence were proper.

B.

REPEATED NEGLIGENCE IS DEFINED BY THE STATUTE, AND DOES NOT REQUIRE A HEIGHTENED FINDING OR A GROSS DEPARTURE FROM THE APPROPRIATE STANDARD OF CARE

The AHC correctly defined and used the legal term "repeated negligence" in its Decision. One of the causes for discipline listed by the AHC is that Dr. Albanna violated Section 334.100.2(5), RSMo, in that he was found to be guilty of "repeated negligence for his treatment of the patients in Counts II and VI." (L.F. 6). The AHC stated that it would examine the counts to decide if there was "simple negligence" before proceeding to "determine whether it aggregated with our findings in other counts to draw a final conclusion" that Dr. Albanna was subject to discipline for repeated negligence. (L.F. 52).

The definition of repeated negligence that the AHC adopted is taken from Section 334.100.2(5) itself.

Section 334.100.2(5) states:

The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate or

registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:

(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter, For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession.

Repeated negligence is therefore not a technical term, and thus it must be given its plain and ordinary meaning: negligent conduct which occurs on more than one occasion. There is nothing in the statute that qualifies when repeated negligence can be used, or that dictates a heightened standard must be proven in order for discipline to be based on repeated negligence. Missouri law dictates that "statutes must be construed broadly" to suppress wrongdoings, with the idea that the primary purpose of the statutes that

authorize the Board to discipline practitioners is to safeguard the public. *Tendai*, 161 S.W.3d at 371 (Teitelman, J., dissenting).

Dr. Albanna argues that this Court should ignore the plain meaning of the statute and should use the maxim *noscitur a sociis* to “clarify the ambiguity in the present case,” but there is no ambiguity here. (Respondent’s Substitute Brief, 30). Dr. Albanna would have this Court expand the definition of “repeated negligence” to only apply if there is evidence of a “substantial departures from the prescribed norms.” (Respondent’s Substitute Brief, 32). Dr. Albanna posits that because Section 334.100.2(5), RSMo includes gross negligence and incompetency as causes for discipline, the definition for repeated negligence enunciated in the statute itself is somehow ambiguous and cannot equate to more than one occasion of ordinary negligence. This heightened interpretation is not expressed in the statute, and no Missouri court case has found that such a requirement is in line with the statute’s intent and purpose, which is to protect the public.

Dr. Albanna was found by the AHC to have violated the standard of care by proceeding with excessive, unnecessary surgeries on patient S.W. and C.W., which posed a greater risk of harm to these patients as evidenced by the expert testimony given at trial. In the case of S.W., the excessive surgery presented risks to the patient such as greater blood loss, a longer operation, an increased chance of spinal cord injury, more pain, greater limitation of movement, and a transfer of forces to other levels of the spine, which ultimately led to a spinal injury. (L.F. 56)(discussing Dr. Smith’s testimony at L.F., AHC Tr., Vol. I, 87-88). Couple this with the negligence found with regard to C.W., which ultimately caused C.W. to experience burning pain in his leg, and it is obvious that this is

exactly the type of case where discipline is required to protect the public. The AHC used the correct legal standard for repeated negligence.

C.

THE FINDINGS MADE BY THE AHC ARE SUPPORTED BY EVIDENCE IN THE RECORD, AND THE REASONABLE MEDICAL JUDGEMENT RULE DOES NOT APPLY TO THIS CASE SINCE EXPERT TESTIMONY WAS PRESENTED THAT SUPPORTED THE AHC’S FINDING THAT DR. ALBANNA WAS NEGLIGENT IN HIS TREATMENT OF S.W. AND C.W.

Dr. Albanna further claims that there can be no negligence found against Dr. Albanna due to the fact that Dr. Albanna provided a paid expert who stated that Dr. Albanna’s choice of treatment for patients S.W. and C.W. was reasonable. Again, Dr. Albanna attempts to claim that the mere presentation of an expert who states that Dr. Albanna’s conduct was not a violation of the standard of care precludes the AHC from making any finding of negligence whatsoever, unless the AHC categorically finds that Dr. Albanna’s experts are not credible to testify. (Respondent’s Substitute Brief, 33). Dr. Albanna further posits that the legislature created the “difficulty of the Board’s task” in disciplining the license of a physician, and that the “legislature has only authorized the Board to discipline the gross departures from the standards of practice that the public safety demands, and for which monetary discipline is insufficient.” (Respondent’s Substitute Brief, 34). This view is not supported by any language in the statute, and flies in the face of the stated purpose of the Board, which is to protect the public.

The AHC's decision that Dr. Albanna is subject to discipline for repeated negligence is consistent with the legal standard for repeated negligence, and is supported by competent and substantial evidence. The Board did not discipline Dr. Albanna's medical license based on a single finding of ordinary negligence. The Board's discipline was based on the AHC's findings, which state that Dr. Albanna is subject to discipline for (among other things) repeated negligence. While the AHC did find that some of Dr. Albanna's actions constituted ordinary negligence, the Decision only found cause to discipline for those actions when considered as a whole, and when they reached the level of repeated negligence. (*See* L.F. 6, 57, 80.)

Patient S.W.

The Commission found that Dr. Albanna was subject to discipline based on his treatment of patient S.W. Dr. Albanna was found to be negligent, unprofessional, and Dr. Albanna's conduct was such that it might have been harmful to patient S.W. The AHC based its findings on the testimony and evidence presented at trial that was both competent and substantial. The record clearly indicates that Dr. Albanna performed an unnecessary surgery, which was more intrusive and carried more risks than a foraminotomy, and which Dr. Albanna's own expert Dr. Lichtor stated he would not have recommended based on the evidence in the record. (L.F., AHC Tr., Vol. II, 306:22-307:9). The surgery that Dr. Albanna performed was a "bigger operation" than what Dr. Lichtor would have recommended. (L.F., AHC Tr., Vol. II, 314:6-15).

The Board's expert Dr. Smith is a board certified neurosurgeon who offered testimony based on his review of the medical records, imaging, and depositions in the record relative to Dr. Albanna's treatment of patient S.W. (See L.F., AHC Tr. Vol. I, 36:3- 40:21). Dr. Smith, who has been board certified as a neurosurgeon since 1981, has specialized experience in the field of neurosurgery. Dr. Smith sees neurosurgery patients, treats and diagnoses them, but not as a primary surgeon. (L.F., AHC Tr., Vol. I, 37:11-17). He participates in surgery about once a month, and keeps himself current on issues related to neurosurgery. (L.F., AHC Tr., Vol. I, 38:1-6). Dr. Smith testified that he examined the medical records from S.W.'s hospital stay for her spine surgery, Dr. Albanna's office notes, imaging reports, consultation reports, and imaging done on patient S.W. (L.F., AHC Tr., Vol. I, 40:8-16).

Dr. Smith is qualified to give expert testimony in the field of neurosurgery based on his education and experience, and his testimony was correctly allowed by the AHC. Dr. Smith gave competent and substantial testimony about the standard of care, and Dr. Albanna's treatment of patient S.W. The AHC acknowledged that Dr. Smith has not practiced as a primary neurosurgeon since 1985, but that he assists once a month with surgery; moreover, the AHC correctly stated that any question about the recency of Dr. Smith's experience and training go to the weight of his testimony, and not its admissibility. (L.F. 45-46)(discussing *State v. Boone Retirement Center*, 26 S.W.3d 265, 276 (Mo. App. W.D. 2000)). The admission of Dr. Smith's testimony is discretionary, and because Dr. Smith demonstrated his board certification and experience as a neurosurgeon, his testimony was properly allowed by the AHC.

At trial, the Board presented evidence from Dr Smith that there were two surgeries that would have been appropriate for patient S.W. based on the imaging that was in evidence, and those two surgeries were an anterior cervical discectomy with a fusion, or a bilateral foraminotomy posteriorly done at level C6-7. (L.F., AHC Tr., Vol. I, 82:11-18). Dr. Albanna performed a laminectomy and lateral mass fusion, performed at levels C3-7. (L.F., AHC Tr., Vol. I, 81:22, 84:1-8). Dr. Smith noted that the record that he reviewed did not justify any operation at the C3-4 level, and that there was no spinal cord compression at any cervical level. (L.F., AHC Tr., Vol. I, 83:3-11). Dr. Albanna performed a surgery that Dr. Smith testified was a “radical, unwarranted operation.” (L.F., AHC Tr., Vol. I, 70:25-71:2). Dr. Smith further stated that by performing such an operation, Dr. Albanna “grossly” violated the standard of care. (L.F., AHC Tr., Vol. I, 82:4-6).

There was competent and substantial evidence presented to support the AHC’s finding that Dr. Albanna was negligent in his treatment of patient S.W.

Patient C.W.

The AHC found that Dr. Albanna was subject to discipline based on his treatment of patient C.W. Dr. Albanna’s treatment of C.W. was negligent, unprofessional, and conduct that was or might be was harmful to the patient. The Board relied primarily on the expert testimony of Dr. Thomas Freeman. Dr. Freeman testified that he is a board certified neurosurgeon who based his opinions on review of the medical records and imaging that were entered into the record in this case. (Board’s Supp. L.F., 9:22-10:19).

Dr. Freeman is a professor of neurosurgery at the University of South Florida, and he is medical director for the Center for the Aging and Brain Repair. (Board’s Supp. L.F., 5:9-16). Dr. Freeman practices neurosurgery at the University of South Florida and at Tampa General Hospital. (Board’s Supp. L.F., 5:4-6).

A. Dr. Albanna violated the standard of care by failing to get patient C.W.’s informed consent

The Board’s expert Dr. Freeman testified that Dr. Albanna failed to get informed consent from patient C.W. for using Pro-Osteon in an off-label manner during patient C.W.’s fusion surgery. (Board’s Supp. L.F., 54:19-22). An off-label use is when a physician uses a product in a manner that is not approved by the FDA; in other words, the physician uses a product “in the absence of any studies showing that” the product works for the purpose for which the physician is using it. (Board’s Supp. L.F., 34:5-9). Pro-Osteon was not approved for use in the spine by the FDA in 1998 “because it had never been shown to fuse in the spine.” (Board’s Supp. L.F., 34:5-7). Dr. Freeman further testified that while it is not uncommon for physicians to use drugs or medical materials in an off-label manner, it is a violation of the standard of care not to inform the patient that a product is being used in a non-FDA approved manner. (Board’s Supp. L.F., 69:11-17). Dr. Freeman stated that the “informed consent process is critical when you use something in an off-label manner.” (Board’s Supp. L.F., 69:17-70:4)(emphasis added).

The AHC found that Albanna offered no direct testimony to refute Dr. Freeman’s testimony. (L.F. 74). Dr. Freeman stressed the importance of informed consent by stating

that it is a “process” that a physician undertakes to give the patient autonomy over their body in regards to making decisions about treatment. (Board’s Supp. L.F., 52:8-24). The informed consent process includes giving the patient the ability to choose whether or not to allow a physician to use a product in a manner that is not approved by the FDA, and by not giving patient CW that option, Dr. Albanna was negligent.

Dr. Albanna argues in his brief that Pro-Osteon 500R has been approved for use in the spine, but what Dr. Albanna fails to state is when Pro-Osteon was approved for use in the spine. As Dr. Freeman testified, Pro-Osteon was not approved by the FDA for use in the spine as of 1998. As such, Dr. Albanna used the product in an off-label manner, and the standard of care required him to get C.W.’s approval before proceeding with the use. Dr. Albanna failed to get C.W.’s informed consent, and there was competent and substantial evidence to support the AHC’s finding that Dr. Albanna’s conduct was negligent.

B. Dr. Albanna violated the standard of care as he destabilized patient

C.W.’s facet joint

At trial the Board’s expert Dr. Freeman testified that Dr. Albanna destabilized the facet joint in patient C.W.’s spine when he had to partially cut away the facet joint in order to place the Ray cage as far to the side as he did in patient C.W.’s spine. Based on Dr. Freeman’s testimony, the AHC found the following facts:

157. In performing the fusion surgery on CW, Albanna placed the first cage on CW’s left side, but placed it too far to the right

side. The cage crossed the midline by five to seven millimeters.

158. Albanna's operating notes state that he performed a "bilateral lumbar microdiscectomy, microlaminotomy, L4-5. Posterior lumbar interbody fusion using autologous bone, applied into Ray cages."

159. CW's post-operative CT scan shows that Albanna did not merely perform a microlaminotomy. In order to place the second cage, Albanna destabilized CW's spine by taking the entire lamina to the facet joint and removing half of the joint. This destabilized the facet joint. This in turn allowed CW's spine to open with flexing and bending, which prevented the bone from fusing. This problem could have been prevented by repositioning the first cage or by stabilizing the spine with pedicle screws or metal rods and screws in the back.

(L.F. 34:157-159)(footnotes omitted).

These findings were based on Dr. Freeman's expert testimony. Dr. Freeman testified that:

"If the joints are intact in back, then as you bend the spine won't open up in back. And so if there's[sic] two cages in the front with bone in them, they have a good chance of fusing. Once the spine opens every time you flex and bend, then that bone will never fuse because the spine is going up and down like an accordion and the bone will never get a chance to fuse. . . [b]y

starting with one cage going off to the side too much, that forced Dr.

Albanna to destabilize the spine in back in order to get the second cage in.”

(Board’s Supp. L.F., 30:12-23).

The AHC specifically found that no expert testimony offered by Dr. Albanna countered Dr. Freeman’s testimony that Dr. Albanna’s actions destabilized C.W.’s spine and contributed to the failure of his fusion. The AHC found “that this aspect of Albanna’s surgical care fell below the standard of care.” (L.F. 78).

Therefore, contrary to the arguments made by Dr. Albanna, the AHC had substantial expert testimony on which to base its conclusion that Dr. Albanna violated the standard of care by destabilizing patient C.W.’s spine in the course of his fusion operation. As the Court is well aware, it is the duty of the AHC to resolve factual issues in the case by making credibility determinations. In this case, the AHC found four of six counts in Dr. Albanna’s favor by accepting Dr. Albanna’s expert testimony as persuasive. On two counts the AHC found in the Board’s favor by accepting the testimony of the Board’s expert witnesses. It is the AHC’s right and duty to make such credibility determinations in a contested case and this Court should not substitute its own factual determinations based on a cold record. The AHC’s findings of fact are based on substantial evidence.

The AHC’s findings of fact are given great deference as the fact-finding process is a function of the agency, and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made.

Fritzshall v. Bd. of Police Comm'rs, 886 S.W.2d 20, 23 (Mo. App. W.D. 1994)(citing *Overland Outdoor Adver. Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. W.D. 1981)).

C. Dr. Albanna violated the standard of care by not recording proper operative notes regarding patient C.W.

Dr. Freeman testified that Dr. Albanna's operative notes fell below the standard of care because they did not give a complete description of what occurred during surgery.

The AHC found that:

159. CW's post-operative CT scan shows that Albanna did not merely perform a microlaminotomy. In order to place the second cage, Albanna destabilized CW's spine by taking the entire lamina to the facet joint and removing half of the joint. This destabilized the facet joint. This in turn allowed CW's spine to open with flexing and bending, which prevented the bone from fusing. This problem could have been prevented by repositioning the first cage or by stabilizing the spine with pedicle screws or metal rods and screws in the back.

(L.F. 34:159)(footnotes omitted).

Dr. Freeman testified:

A. The operative note just says that a microlaminectomy was performed, which is not the case.

Q. What does the postoperative film show?

A. The postoperative film CAT scan demonstrated quite clearly that the entire lamina out to the facet joint was taken out and the facet joint was removed, so only half of the facet joint was left, the other half was completely removed so there was absolutely no stability in that facet joint.”

(Board’s Supp. L.F., 30:1-9).

Dr. Albanna’s notes did not indicate that instead of a microlaminectomy, he performed a much larger operation. Dr. Albanna also failed to describe the full extent of the surgery because he failed to indicate in his operative notes that he destabilized C.W.’s spine by initially placing the first cage over the midline, which forced him to “widen the decompression” area. (Board’s Supp. L.F., 30:9-11). The surgery that was performed by Dr. Albanna reduced the chances that a fusion would occur, and based on Dr. Freeman’s testimony, the AHC found that Dr. Albanna’s failure to indicate what happened during the surgery was a violation of the standard of care. (L.F. 79).

D. Dr. Albanna violated the standard of care by falsely reporting a good fusion

AHC found that Dr. Albanna violated the standard of care by falsely reporting a good fusion, when in fact the evidence indicated that C.W.’s fusion was not progressing, and the Ray cages that were supposed to effectuate the fusion were in fact migrating. (L.F. 80). Ray cages are designed to allow bone to “grow” into the vertebral body, thus

fusing the vertebrae together, which reinforces the spine. (L.F. 33). In this case, C.W.'s spine never properly fused.

The AHC found that Dr. Albanna dictated a note on November 17, 1998 that stated “[his] diagnostic x-rays and CT scan of the lumbosacral spine show unchanged position of the Ray cages at L4-L5 and fusion in progress.” (L.F. 35). Contrary to Dr. Albanna’s statement that a fusion was in progress, the Ray cages that were supposed to allow the fusion to occur were moving. Dr. Freeman testified that his review of the imaging indicated that there “was motion on the flexion/extension x-rays and there were loosencies [sic] around the cages” which is “a sign that the cage is moving” and that “the fusion is not happening.” (Board’s Supp. L.F., 57:10-18). He went on to testify that “if there is motion on flexion/extension x-rays above and below the cage, that’s proof that the bone is not fused.” (Board’s Supp. L.F., 57:18-20). The left cage was found to have migrated so far into the spinal canal that it was pressing on C.W.’s nerves, causing him to experience burning pain in his leg. (L.F. 36; Board’s Supp. L.F., 103:9-19). Dr. Freeman further testified that in the operative notes taken by Dr. Lange who eventually operated on patient C.W. in an attempt to fix C.W.’s failed fusion, Dr. Lange noted that the spine was not fused. (Board’s Supp. L.F., 57:21-22).

Dr. Albanna’s own expert Dr. Raskas testified that the cages had begun to migrate as of July 14th, 1998, well before Dr. Albanna claimed that the fusion was progressing. (Dr. Albanna’s Supp. L.F., Vol. II, 269:59). Dr. Wilkinson, another of Dr. Albanna’s experts, stated that the left cage had begun to move as of October 1998, again before Dr. Albanna’s claim that a fusion was taking place. (L.F., AHC. Tr., Vol. II, 590:10-593:1).

The AHC correctly found that Dr. Albanna violated the standard of care based on competent and substantial testimony and evidence that was in the record. Dr. Albanna was negligent in reporting that a fusion was taking place when the imaging clearly indicated that fusion was not occurring. The AHC's finding therefore should stand.

III.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA ENGAGED IN CONDUCT THAT IS OR MIGHT BE HARMFUL OR DANGEROUS TO A PATIENT BECAUSE ITS HOLDING WAS CORRECTLY BASED ON THE PROPER APPLICATION OF THE LAW IN THAT THERE IS NOT A HEIGHTENED REQUIREMENT THAT THE ONLY CONDUCT THAT CAN BE SANCTIONED BY THE BOARD TO PROTECT THE PUBLIC MUST BE AKIN TO QUACKERY, AND THERE WAS COMPETENT AND SUBSTANTIAL EVIDENCE THAT DR. ALBANNA'S CONDUCT CAUSED OR MIGHT HAVE CAUSED HARM TO PATIENTS S.W. AND C.W.

Point-relied-on number III is multifarious and presents multiple and unrelated questions for review and additionally was not specifically set out in Albanna's Petition for Judicial Review and therefore preserves nothing for review by this Court.

Dr. Albanna in this point-relied-on preserves nothing for review as the point-relied-on is multifarious and presents multiple and unrelated questions for review. Therefore, this point-relied-on fails to meet the requirements of Civil Rule 84.04(d)(1) and (2). *Law Offices of Gary Green, P.C.*, 210 S.W.3d at 424. In addition, the substance of this point-relied-on was not set out in the *Petition for Judicial Review* filed in Circuit

Court and therefore this legal point was not preserved for review.³ *Chipperfield*, 229 S.W.3d 226, at fnt. 10; *Edwards*, 85 S.W.3d at 21; *Ruffin*, 849 S.W.2d at 114. Point-relied-on number IV should be dismissed by the Court.

In paragraph 8(e) of the Cole County *Petition for Judicial Review*, Albanna states as follows: “the facts as found and the application of law clearly demonstrate that Faisal J. Albanna, M.D. was not guilty of any unprofessional conduct.” (L.F. 3-4:8(e)). The Cole County *Petition for Judicial Review* did not address any error regarding conduct that was or might be harmful to the patient. The Cole County *Petition for Judicial Review* also did not include any claim that the AHC erred “because its holding is based upon an erroneous application of the law in that the conduct sanctioned by discipline under the statute is akin to quackery, and is not judged by post hoc review of physician skill or patient outcome, and because it is unsupported by substantial evidence in that there is no testimony that, “but for” Dr. Albanna’s actions, his patients would have suffered no harm. It does not appear that Dr. Albanna otherwise questioned the findings of incompetency elsewhere in his *Petition for Judicial Review*. (See L.F. at 114-118). Dr. Albanna therefore failed to raise the quoted points from his point-relied-on number IV in his *Petition for Judicial Review* and therefore failed to preserve these points for review.

Furthermore, Dr. Albanna raises the “but for” argument in his point-relied-on III, but failed to make any such argument regarding the requirement in the argument section

³ *The Petition for Judicial Review* is found at page 1 of the Record on Appeal. A copy of *the Petition for Judicial Review* is included in the Appendix for ready reference.

of his *Respondent's Substitute Brief Pursuant to Rule 84.05(e)*. Rule 83.08(b) specifically states that

“[A] party may file a substitute brief in this Court. The substitute brief shall conform with Rule 84.04, shall include all claims the party desires this Court to review, shall not alter the basis of any claim that was raised in the court of appeals brief, and shall not incorporate by reference any material from the court of appeals brief. Any material included in the court of appeals brief that is not included in the substitute brief is abandoned.”

Dr. Albanna has not included any argument regarding a “but for” requirement for proving conduct that is or might be harmful to a patient in his *Respondent's Substitute Brief Pursuant to Rule 84.05(e)*, and therefore he has waived this argument.

Standard of Review

Judicial review of the orders of the AHC is authorized under the provisions of Sections 621.145, RSMo, as well as Sections 536.100 through 536.150, RSMo. The order and decision of the AHC in this case, as represented by its Findings of Fact and Conclusions of Law, entered on December 27, 2004, may be reviewed and challenged only if the agency action:

- (A) is in excess of statutory authority and/or jurisdiction of the Commission;
- (B) is unsupported by competent and substantial evidence upon the whole record;
- (C) is unauthorized by law;

- (D) is arbitrary, capricious and unreasonable;
- (E) involves abuse of discretion;
- (F) erroneously announces and applies Missouri law; and therefore is

reviewable by this Court under the provisions of Section 621.145, RSMo, and Section 536.140, RSMo.

In an appeal from an administrative appeal, the courts must review the decision of the administrative agency rather than the circuit court. *Psychcare Mgt. v. Dept of Social Services*, 90 S.W.2d 311, 312 (Mo. banc 1998). In Missouri, an appellant court's review of an administrative decision is clearly defined, and limited in scope. The AHC decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo. Upon review in a physician licensure proceeding, decisions by the AHC are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W.2d 894, 900 (Mo. App. 1997). The agency's findings of fact are given great deference as the fact-finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo. App. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. 1981)).

This Court has stated that appellate courts must look at the entire record in reviewing an agency's decision. *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004). The appellate court should not redetermine the issues

on appeal, but should look at the entire record to determine whether there is competent and substantial evidence to support the agency's findings. *Id.*

Argument

The AHC found that Dr. Albanna was subject to discipline for conduct that was or might be harmful to patients S.W. and C.W. The AHC specifically found that Dr. Albanna engaged in conduct that might have been harmful to the patient by performing an inappropriate operation on patient S.W., and by falsely reporting a good fusion for patient C.W. The AHC also found that Dr. Albanna engaged in conduct that was harmful to patient C.W for the following actions: (1) failing to differentiate between muscular and disk pain by not performing additional diagnostic testing before recommending and operating on patient C.W., (2) performing fusion surgery rather than the simpler discectomy, and (3) failing to recognize problems that developed after surgery, which prevented the fusion from occurring.

Dr. Albanna argues (for the first time) in his *Respondent's Substitute Brief* that the conduct or practice clause of Section 334.100.2(5) must equate to practices that he calls "quackery." The argument is not supported by any case law or even the language of the statute, and it is inconsistent with the reading of the statute itself. Dr. Albanna states that Section 334.100.2, RSMo, contains several provisions that authorize discipline for conduct that is commonly called "quackery." (Respondent's Substitute Brief, 34). There are, however, several subsections that cannot be considered quackery, but instead authorize the Board to discipline for such things as forgetting to inform the Board of a

new address, or not paying dues on time. (See Sections 334.100.2(4)(n), and (p), RSMo). Dr. Albanna's argument that the legislature could not have authorized discipline for "conduct and practice alone, without reference to the skills or results of the licensee's performance" is not supported by looking at the rest of Section 334.100.2 as he suggests, and his theory is not supported by any evidence presented whatsoever. The AHC based its findings on the plain meaning of the statute, and on established Missouri case law that defines the statute itself. The AHC used the proper legal standard for conduct that is or might be harmful or dangerous to the mental or physical health of the patient or the public.

A. Conduct that might be harmful or dangerous to the patient

The AHC found that Dr. Albanna was subject to discipline for conduct that might be harmful when the conduct's "harm or danger (that is, its potential harm) outweighs its potential medical benefit." (L.F. 50). The legal standard used by the AHC is consistent with that used by the court in *Moheet v. State Bd. of Registration for the Healing Arts*, 154 S.W.3d 393 (Mo. App. W.D. 2004). The Western District Court applied a plain and ordinary meaning interpretation to Section 334.100.2(5), which provides for discipline for "[a]ny conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public." The AHC's findings were based on testimony of the Board's qualified expert witnesses which were given after extensive reviews of the medical records in evidence, and the legal standard is met, the findings are supported by competent and sufficient evidence, and should be upheld.

The AHC found that Dr. Albanna's excessive surgery on patient S.W. was "conduct that might be harmful to the patient." (L.F. 57). The AHC specifically found that there was "insufficient evidence to warrant the very extensive operation" that he performed on patient S.W. (L.F. 57). The AHC stated that "[i]n accordance with our decision in *State Bd. of Registration for the Healing Arts v. Prince*, No. 03-0384 HA (Admin. Hearing Comm'n, Sept. 24, 2004), we conclude that a practice or other conduct is cause for discipline when its harm or danger (that is, its potential harm) outweighs its potential medical benefit." (L.F. 50). The finding was based on the evidence in the record, which included Dr. Smith's testimony.

Dr. Smith testified that proceeding with a four-level laminectomy and fusion as opposed to the one level laminectomy (which was the only surgery supported by the medical record in evidence) posed a greater risk to patient S.W. Dr. Smith listed the increased risks of the surgery that Dr. Albanna performed on S.W., and they included a longer operation, more pain, a higher degree of scarring, more blood loss, more chance of spinal cord and nerve injury, a longer recovery period, more limited spinal movement, prolonged immobilization period, and also the increase of spinal loads at the C3-C4 to C2-C3. (L.F., AHC Tr., Vol. I, 87:16-88:12). Dr. Smith further stated that the four-level fusion put "enormous stresses transmitted above and below the level of fusion" and "will overload structures that were not designed to carry that type of burden." (L.F., AHC Tr., Vol. I, 88:21-89:1). Just days after surgery S.W. suffered a central cord syndrome, which Dr. Smith stated was the result of the four-level fusion, which destabilized S.W.'s spine. (L.F., AHC Tr., Vol. I, 84:9-86:11).

The *Moheet* court addressed the legal standard for “conduct that might have been harmful to a patient.” 154 S.W.3d 393. In *Moheet*, the court found that the physician was subject to discipline by the Board of Registration for the Healing Arts for conduct that might have been harmful to one of his patients. *Id.* at 400-01. In the *Moheet* case, Dr. Moheet failed to assess the blood pressure of a patient who presented to the emergency room with neck pain. *Id.* at 395-96. The patient had high blood pressure, but Dr. Moheet failed to run any tests related to the patient’s blood pressure, and therefore misdiagnosed his pain as radiculopathy. *Id.* The following day the patient suffered a hemorrhagic stroke that put him into a coma and required emergency surgery to avoid imminent death. *Id.* at 396-97. A CT scan run on the day of the patient’s first visit to the Emergency room would have revealed the hemorrhage in the patient’s brain. *Moheet*, 154 S.W.3d at 397. In the *Moheet* case, there was no doubt that Dr. Moheet’s conduct carried a risk of substantial injury to the patient. *Id.* at 403. In this case, there is also no doubt that proceeding with a medically unwarranted surgery carried the risk of substantial injury to patient S.W.

The court in *Moheet* also found that testimony by an expert in the field was enough to justify the AHC’s decision that Dr. Moheet’s action might have been harmful to the patient. *Id.* at 402-03. In this case, Dr. Smith, a Board certified neurosurgeon, testified as to the risks of the surgery that Dr. Albanna chose to perform on S.W. even though the medical records failed to show that the surgery was appropriate.

In short, the AHC found that Dr. Albanna’s conduct towards S.W. “might be harmful to the patient” based on expert testimony after the expert reviewed medical

records and imaging that was included as part of the record. Therefore, the AHC's finding that Dr. Albanna's was subject to discipline is supported by competent and substantial evidence in the record. The *Moheet* court found that the "theory of Section 334.100.2(5) is that the public is best protected by ensuring that physicians seek to protect against unprofessional failure that *might* result in harm to patients." *Moheet*, 154 S.W.3d at 404.

Similarly, the AHC found that Dr. Albanna was subject to discipline for conduct that might be harmful to patient C.W. when Dr. Albanna falsely reported that a fusion was taking place in C.W.'s spine. (L.F. 80). Dr. Albanna initially reported that the fusion was progressing as early as November 17, 1998. (L.F. 35). Dr. Albanna's own experts noted that the imaging demonstrated that the Ray cages, the instrumentation installed to hold the spine in place to facilitate the fusion, were migrating even before the date that Dr. Albanna claimed the fusion was progressing. The left Ray cage eventually pulled back from the vertebral body into the spinal canal, and Dr. Albanna's expert Dr. Wilkinson agreed that the cage had moved by October of 1998. (L.F., AHC Tr., Vol. I, 590:10-593:1).

At the time that Dr. Albanna falsely reported the fusion was progressing, C.W. was experiencing burning pain in his legs as a result of the Ray cage pressing on the nerves in the spine due to the movement of the cage. (Board's Supp. L.F., 37:9-14). Dr. Freeman specifically stated that based on his review of the records, the left cage "could clearly be seen pulling back into the spinal canal, and it finally settled about three millimeters into the spinal canal." (Board's Supp. L.F., 37:7-9). Dr. Freeman further

reports that Dr. Lange, who ended up removing the cage after C.W. had stopped seeing Dr. Albanna, wrote in his medical notes that “neither cage had fused.” (Board’s Supp. L.F., 37:15-23).

The AHC found that Dr. Albanna falsely reported a fusion was taking place, when in fact there was no such fusion occurring due the migration of the Ray cages in C.W.’s spine. The legal standard is not erroneous, and the findings made by the AHC are relevant for the purpose of protecting the public against physicians that may cause harm. The AHC correctly found that Dr. Albanna’s license is subject to discipline based on conduct that might be harmful to his patients. The migration ended up causing C.W.’s leg pain and therefore Dr. Albanna is subject to discipline for conduct that might be harmful to the patient.

B. Conduct that was harmful to the patient

The AHC found that Dr. Albanna was subject to discipline for conduct that was harmful to patient C.W. Specifically, the AHC found that the following conduct was conduct that was harmful to patient C.W.: (1) failing to differentiate between muscular and disk pain by not performing additional diagnostic testing before recommending and operating on patient C.W., (2) performing fusion surgery rather than the simpler discectomy, and (3) failing to recognize problems that developed after surgery, which prevented the fusion from occurring.

Dr. Albanna has previously argued that the *Tendai* case illustrates that there must be conduct that is shown to have caused injury to the patient, or that “but for” Dr.

Albanna's negligence, injury would have not have occurred. In the *Tendai* case, Dr. Tendai was found not to be subject to discipline for conduct that was harmful to a patient for not referring the patient to a specialist, where ultimately the patient, a pregnant woman, gave birth to a still born child. *Tendai*, 161 S.W.3d at 358. This Court in *Tendai* found that there was not enough evidence to support a finding that Dr. Tendai's inaction caused the baby's death. *Id.* at 369-371. In this case, Dr. Albanna performed unwarranted surgery on patient C.W., based on his failure to perform adequate testing. Furthermore, Dr. Albanna failed to recognize and correct surgical errors that led to the destabilization of patient C.W.'s spine. Unlike Tendai's repeated failure to act, Dr. Albanna made several affirmative acts that evidence demonstrated caused harm to patient C.W. These failures ultimately led to the failure of C.W.'s fusion surgery, and when combined with the evidence that C.W. experienced pain in his leg due to the Ray cage migrating into the nerves in his spinal canal, the AHC's finding that Dr. Albanna's conduct caused harm to patient C.W. is clearly supported by competent and substantial evidence. (L.F. 34-35, 78; Board's Supp. L.F., 37:9-38:9, 103:9-19). The Board clearly established that Dr. Albanna's negligent conduct directly harmed patient C.W. This was not a case where Dr. Albanna failed to take action.

Section 334.100.2(5), RSMo states that a physician may be subject to discipline for “[a]ny conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public, or incompetency, gross negligence or repeated negligence.” (emphasis added.) The statute, by the inclusion of the word “or” after the conduct that might or is harmful to a patient, clearly does not require a finding of

incompetency, gross negligence, or repeated negligence to be actionable. Dr. Albanna argues that the *Tendai* case adds such a requirement, but the *Tendai* case specifically addressed a finding that was made under a repeated negligence charge when it stated that the Board had no authority to discipline a physician for ordinary negligence, not a charge of conduct that was or might have been harmful to patient. *See Tendai*, 161 S.W.3d at 368-69. To read the statute otherwise would severely inhibit the Board's authority to discipline physicians in the name of protecting the public, and it disregards the plain language of the legislature.

Dr. Albanna's actions were the cause of the harm, and there is sufficient evidence in the record to support these findings. The *Moheet* court stated that expert opinions based on facts in evidence are enough to support findings that conduct was or might be harmful to a patient. *Moheet*, 154 S.W.3d at 402-03. The testimony of Dr. Freeman points to the increased harm for patient C.W., and Dr. Freeman's opinions are based on his review of the medical records and imaging that are part of the records of this case. Dr. Freeman's testimony indicates that the Ray cages eventually moved into the area of the spinal canal, causing him to experience burning pain in his leg. The actions of Dr. Albanna caused CW to experience pain and eventually forced C.W. to have the cages removed via another surgery, performed by Dr. Lange. As previously stated, the surgery by Dr. Lange required movement of the nerves, and in doing so, more damage was done to the nerves.

The AHC found that Dr. Albanna failed to differentiate between muscular and disk pain on patient C.W. before subjecting him to a diskectomy and fusion. (L.F. 71).

The AHC specifically found that Dr. Freeman's testimony was "persuasive that additional diagnostic procedures were necessary before subjecting C.W. to a fusion as well as a diskectomy." (L.F. 71). In his deposition, Dr. Freeman noted that most people who suffer from back pain suffer from muscular pain, and that Dr. Albanna did not adequately differentiate C.W.'s type of back pain before performing the diskectomy and fusion. (Board's Supp. L.F., 15:11-17:11). Dr. Freeman testified that the MRI did not show problems that would lead to the type of back pain that would benefit from a fusion. (Board's Supp. L.F., 26:17-20). By not differentiating between muscular and diskogenic pain, Dr. Albanna subjected CW to a surgery that might not even address the underlying problem, especially when "about 90% of people that have back pain have primarily muscular back pain." (Board's Supp. L.F., 17:17-19). A fusion in that instance would not help with muscular pain, and therefore would be entirely unnecessary.

By not differentiating between the two types of back pain, and because the MRI did not show that a fusion was appropriate, Dr. Albanna chose to proceed with a surgery that was excessive. Dr. Albanna's decision to proceed with a diskectomy and fusion was found by the AHC to be harmful to the patient. (L.F. 73). The AHC examined the testimony of the experts in the case, and accepted Dr. Freeman's testimony that a simple diskectomy was the proper procedure given the circumstances in evidence. (L.F. 73). Dr. Albanna's expert Dr. Raskas, an orthopedic surgeon, testified that he would have performed the fusion, but Dr. Freeman stated that performing the fusion was not justified by the record. Even Dr. Albanna's expert Dr. Wilkinson stated that he would not have performed a fusion, but instead would have performed a diskectomy, as was supported by

Dr. Freeman. (L.F., AHC Tr., Vol. II, 560:19-20). The decision to proceed with the fusion, when the MRI failed to indicate any problem that would be solved by this extensive type of surgery is conduct that was harmful to patient C.W.

The evidence clearly points to the fact that this type of surgery was not indicated by the record, and that the failed fusion allowed the Ray cages to migrate into the spinal canal, thereby pushing on the nerves in C.W.'s spine. Dr. Freeman testified that the fusion failed, causing the instrumentation to push in to the nerves in C.W.'s spine, "and this was leading to progressive burning pain in [C.W.'s] leg as the nerves were being compressed by this cage as it pushed into the spinal canal." (Board's Supp. L.F., 37:9-14). Also, the fusion failed to work as planned, and C.W. was subjected to more surgery by another physician to remove the Ray cages that were causing his pain, which damaged C.W.'s nerves even further. Therefore Dr. Albanna's choice of surgery was shown to have directly caused the need for additional surgery and caused excessive pain that a simpler discectomy would have avoided. The AHC correctly found that Dr. Albanna subjected C.W. to unwarranted surgery that led to pain and additional operations, and was therefore subject to discipline for conduct harmful to the physical health of the patient.

The AHC also found that Dr. Albanna failed to recognize the surgical errors that he made after he performed the surgery on patient C.W., which amounted to "conduct that was harmful to the mental and physical health of the patient." (L.F. 79). Dr. Freeman testified that Dr. Albanna misplaced the Ray cages in C.W.'s back during the operation. (Board's Supp. L.F., 28:6-25). As a result of the misplaced cage, Dr. Albanna was forced to widen the surgical decompression to the point where he destabilized the

spine. (Board's Supp. L.F., 30:20-23). While the AHC found that the displacement of the Ray cage was not in itself a violation of the standard of care, it was found to have destabilized C.W.'s spine due to the fact that the cages were not placed in the correct space. (L.F. 34). The fact that the spine was destabilized ultimately prevented the bone from fusing together because the spine was able to move and flex. (Board's Supp. L.F., 30:15-19). Dr. Freeman testified that the post-operative x-rays "show quite clearly that the cage was not in a good position." (Board's Supp. L.F., 30:23-31:3).

Dr. Albanna could have remedied his mistake and stabilized C.W.'s spine to allow for the fusion to properly proceed, but instead nothing was done, thus allowing the cages to migrate into the spinal canal and causing C.W. to experience burning pain in his leg. The fact that the mistake was not recognized and corrected is supported by the testimony of Dr. Freeman and the evidence in the record, and therefore the AHC correctly found that it was conduct that was harmful to patient C.W.

IV.

THE AHC DID NOT ERR IN HOLDING THAT DR. ALBANNA WAS INCOMPETENT BECAUSE SUCH HOLDING WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE, AND IS CONSISTENT WITH A FINDING OF GENERAL LACK OF, OR LACK OF DISPOSITION TO USE, A PROFESSIONAL ABILITY.

Point-relied-on number IV is multifarious and presents multiple and unrelated questions for review and additionally was not specifically set out in Albanna's Petition for Judicial Review and therefore preserves nothing for review by this Court.

Dr. Albanna in this point-relied-on preserves nothing for review as the point-relied-on is multifarious and presents multiple and unrelated questions for review. Therefore, this point-relied-on fails to meet the requirements of Civil Rule 84.04(d)(1) and (2). *Law Offices of Gary Green, P.C.*, 210 S.W.3d at 424. In addition, the substance of this point-relied-on was not set out in the Petition for Judicial Review filed in Circuit Court and therefore this legal point was not preserved for review.⁴ *Chipperfield*, 229 S.W.3d 226, at fnt. 10; *Edwards*, 85 S.W.3d at 21; *Ruffin*, 849 S.W.2d at 114. Point-relied-on number IV should be dismissed by the Court.

⁴ *The Petition for Judicial Review* is found at page 1 of the Record on Appeal. A copy of *the Petition for Judicial Review* is included in the Appendix for ready reference.

In paragraph 8(d) of the Cole County *Petition for Judicial Review*, Albanna states as follows: “The facts as found and the application of law clearly demonstrates that Albanna was not guilty of any incompetence in the performance of his functions and duties as a physician” and “[t]he decision is in excess of statutory authority . . . and is unauthorized by law.” (L.F. 115-16:8(d), (h)). The Cole County *Petition for Judicial Review* did not include any claim that “the AHC erred in holding that Dr. Albanna was incompetent because such holding is unsupported by the evidence in the record in that Dr. Albanna has successfully performed more than 8,500 surgical procedures over a fifteen year career, which is inconsistent with a finding of a general lack of professional ability, and there is no evidence of record showing incompetency.” It does not appear that Dr. Albanna otherwise questioned the findings of incompetency elsewhere in his *Petition for Judicial Review*. (L.F. 114-118). Dr. Albanna therefore failed to raise the quoted points from his point-relied-on number IV in his Cole County *Petition for Judicial Review* and therefore failed to preserve these points for review.

Standard of Review

Judicial review of the orders of the AHC is authorized under the provisions of Sections 621.145, RSMo, as well as Sections 536.100 through 536.150, RSMo. The order and decision of the AHC in this case, as represented by its Findings of Fact and Conclusions of Law, entered on December 27, 2004, may be reviewed and challenged only if the agency action:

- (A) is in excess of statutory authority and/or jurisdiction of the Commission;

(B) is unsupported by competent and substantial evidence upon the whole record;

(C) is unauthorized by law;

(D) is arbitrary, capricious and unreasonable;

(E) involves abuse of discretion;

(F) erroneously announces and applies Missouri law; and therefore is reviewable by this Court under the provisions of Section 621.145, RSMo, and Section 536.140, RSMo.

In an appeal from an administrative appeal, the courts must review the decision of the administrative agency rather than the circuit court. *Psychcare Mgt. v. Dept of Social Services*, 90 S.W.2d 311, 312 (Mo. banc 1998). In Missouri, an appellate court's review of an administrative decision is clearly defined, and limited in scope. The AHC decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo. Upon review in a physician licensure proceeding, decisions by the AHC are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W.2d 894, 900 (Mo. App. 1997). The agency's findings of fact are given great deference as the fact-finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo. App. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. 1981)).

This Court has stated that appellate courts must look at the entire record in reviewing an agency's decision. *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004). The appellate court should not redetermine the issues on appeal, but should look at the entire record to determine whether there is competent and substantial evidence to support the agency's findings. *Id.*

Argument

The AHC found that Dr. Albanna's failure to perform adequate diagnostic procedures prior to C.W.'s fusion surgery constituted incompetence. Dr. Freeman testified that Albanna failed to sufficiently differentiate between pain resulting from the disk itself ("discogenic" pain) and muscular pain, which is much more common. Dr. Freeman further testified that the MRI on C.W. did not show disk problems that would cause the type of back pain helped by a fusion, e.g. pain located in the disk itself rather than muscle pain caused by the protrusion of a disk. Dr. Freeman testified that Dr. Albanna should have ordered further diagnostic procedures, including a bone scan and a diskogram, before performing the extremely intrusive fusion surgery. (Board's Supp. L.F., 22:12-23:25). Even Dr. Albanna's own expert, Dr. Wilkinson, testified that he would have performed only a discectomy on C.W., which supports Dr. Freeman's position that the MRI warranted only a discectomy but not a fusion.

The AHC also found that Dr. Albanna's failure to obtain informed consent from C.W. fell below the standard of care. Dr. Freeman testified that the standard of care requires a surgeon to outline the basic options of surgery for a patient. (Board's Supp.

L.F., 52:25-53:7). Therefore, Dr. Albanna violated the standard of care because he failed to inform C.W. that other, less radical surgical options were available to treat his condition. Rather than explaining these options to C.W., Dr. Albanna described only the procedure that he planned to perform. Several experts, including Dr. Albanna's expert Dr. Wilkinson, testified that there were at least two alternative options – a microdiscectomy and an open laminectomy - which would have been appropriate to treat C.W.'s condition and should have been presented to C.W. as options. By failing to apprise C.W. of any surgical alternatives, Dr. Albanna did not obtain informed consent and thus violated the standard of care.

Moreover, Dr. Albanna also failed to get informed consent from C.W. for his off-label (non-FDA approved) use of Pro-Osteon during the surgery. While off-label use is generally accepted, the standard of care for such use requires that the physician obtain informed consent from the patient. To obtain informed consent for off-label use, a physician must inform the patient that the intended use is not approved by the FDA, and allow the patient to decide whether to proceed by weighing the risks and benefits of the non-approved use. Patient C.W. testified that Dr. Albanna described only the possibility of using bone from the hip, and did not mention the potential off-label use of Pro-Osteon in the spine. (L.F., AHC. Tr., Vol. II, 368:14-23). Therefore, Dr. Albanna violated the standard of care because he did not inform C.W. of the potential off-label use of Pro-Osteon, and did not allow C.W. the opportunity to decide whether to approve its use in his surgery. Dr. Albanna thus failed to obtain C.W.'s informed consent for both the surgery itself and the use of Pro-Osteon. The AHC's finding of incompetence based on

Dr. Albanna's failure to get C.W.'s informed consent demonstrates his general lack of present ability, or lack of disposition to use, a present ability to perform his duties as a neurosurgeon.

The AHC also found that numerous aspects of Dr. Albanna's conduct during C.W.'s surgical procedure fell below the standard of care. Based on the testimony of Dr. Freeman (which "no persuasive testimony countered"), the AHC found that Dr. Albanna's surgical technique and his failure to recognize surgical errors unnecessarily destabilized C.W.'s spine and contributed to the failure of his fusion. (L.F. 78). The AHC found that Dr. Albanna failed to recognize his misplacement of the first Ray cage, and did not attempt to remove and reposition it or to stabilize the spine with additional instrumentation, either of which would have compensated for his initial error. (L.F. 78).

Although "any surgeon can put a cage in off [-centered]," the AHC correctly found that Dr. Albanna's failure to recognize and remedy his initial misplacement of the Ray cage violated the standard of care, and led to the destabilization of C.W.'s spine and the failure of his fusion. (L.F. 73-74). Moreover, the AHC found that Dr. Albanna failed to record proper operative notes about the surgery, as he omitted many significant facts and mistakenly noted that he performed a microlaminectomy, when in fact he removed the entire lamina to the facet joint. (L.F. 74). In addition, the AHC found that Dr. Albanna failed to document that he destabilized the spine in order to insert the Ray cage. (L.F. 74).

Even after surgery was completed, Dr. Albanna's conduct in relation to patient C.W. continued to fall below the standard of care, as he misrepresented that C.W.'s

fusion was progressing even though imaging showed that no such fusion was occurring. (Board's Supp. L.F., 57:10-18). The AHC found that on November 17, 1998, Dr. Albanna noted in his medical records the "unchanged position" of the cages and that the fusion [was] in progress." (L.F. 35). However, Dr. Albanna's own expert Dr. Raskas testified that the left cage had begun to migrate by July, 1998. (Dr. Albanna's Supp. L.F., 270:59). Another of Dr. Albanna's experts testified that the left Ray cage had moved by October, again before Dr. Albanna noted in November that the fusion was progressing.

Although a single act of negligence cannot support a finding of incompetency, Dr. Albanna's conduct fell below the standard of care numerous times during his treatment of patient C.W. Dr. Albanna's many violations of the standard of care regarding patient C.W. demonstrate an overall lack of, or lack of disposition to use his professional ability. This amounts to incompetency under Section 334.100.2(5), RSMo, and therefore the AHC correctly found that Dr. Albanna's medical license was subject to discipline based on the overwhelming evidence that supports this finding.

V.

THE BOARD DID NOT ERR IN ITS IMPOSITION OF DISCIPLINE BECAUSE PLACING DR. ALBANNA'S LICENSE ON A PROBATIONARY PERIOD WAS FAIR AND AUTHORIZED BY LAW, IN THAT THE DISCIPLINE WAS JUSTIFIED BY STATUTORY AUTHORITY, WAS REQUIRED TO PROTECT THE PUBLIC, WAS NOT DISCRIMINATORY, AND WAS THE RESULT OF A FAIR AND IMPARTIAL HEARING.

Standard of Review

Judicial review of the orders of the AHC is authorized under the provisions of Sections 621.145, RSMo, as well as Sections 536.100 through 536.150, RSMo. The order and decision of the AHC in this case, as represented by its Findings of Fact and Conclusions of Law, entered on December 27, 2004, may be reviewed and challenged only if the agency action:

- (A) is in excess of statutory authority and/or jurisdiction of the Commission;
- (B) is unsupported by competent and substantial evidence upon the whole record;
- (C) is unauthorized by law;
- (D) is arbitrary, capricious and unreasonable;
- (E) involves abuse of discretion;

(F) erroneously announces and applies Missouri law; and therefore is reviewable by this Court under the provisions of Section 621.145, RSMo, and Section 536.140, RSMo.

In an appeal from an administrative appeal, the courts must review the decision of the administrative agency rather than the circuit court. *Psychcare Mgt. v. Dept of Social Services*, 90 S.W.2d 311, 312 (Mo. banc 1998). In Missouri, an appellant court's review of an administrative decision is clearly defined, and limited in scope. The AHC decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo. Upon review in a physician licensure proceeding, decisions by the AHC are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W.2d 894, 900 (Mo. App. 1997). The agency's findings of fact are given great deference as the fact-finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo. App. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. 1981)).

This Court has stated that appellate courts must look at the entire record in reviewing an agency's decision. *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004). The appellate court should not redetermine the issues on appeal, but should look at the entire record to determine whether there is competent and substantial evidence to support the agency's findings. *Id.*

Argument

Dr. Albanna's initial Cole County Petition for Judicial Review fails to set forth the argument that the Board's discipline violates Dr. Albanna's Equal Protection Rights. In Dr. Albanna's Petition for Judicial Review at paragraph 8(g), he discussed "[t]he limitations placed on Faisal J. Albanna's license are excessive and unlawful under the provisions of the Missouri Statutes, and under the provisions of the Due Process Clauses of Amendment XIV of the United States Constitution and Article 1, Section 2 of the Missouri Constitution." He failed to timely raise an Equal Protection argument at the first opportunity, and continue to preserve the issue for review, and has therefore waived any and all such constitutional arguments. *Joplin Surgical Assoc., Inc. v. Smith*, 731 S.W.2d 523, 523 (Mo. App. S.D. 1987); *Christiansen v. Fulton State Hospital*, 536 S.W.2d 159, 160 (Mo. banc 1976).

Dr. Albanna argues in his *Substitute Brief* that the Board was motivated solely by a desire and intent to punish Dr. Albanna rather than any attempt to protect the public. (Respondent's Substitute Brief, 64). There is nothing presented to justify this position other than a showing that other physicians who have been disciplined by the Board have been disciplined in dissimilar manners. This does not rise to a finding that the Board is somehow out to punish Dr. Albanna, but instead it indicates the severity of the actions that Dr. Albanna has been found guilty of, and it does indicate that the Board feels that it is important to put safeguards in place that will both protect the public and allow Dr. Albanna to continue to perform neurosurgery.

As the Commission stated, Dr. Albanna is an aggressive surgeon who “treats patients with difficult and dangerous conditions that others might not treat.” The Board also notes the Commission’s findings that Dr. Albanna “over-diagnosed and over-treated” certain patients, and therefore in order to protect the public from similar incidents, the Board placed narrowly tailored restrictions on Dr. Albanna. There is nothing here to prove that the actions of the Board were not initiated on a good faith belief that there was reason to do so in order to protect the public. Dr. Albanna’s accusations do not indicate that the Board, with independent findings for discipline made by the AHC, acted in a manner that violated Dr. Albanna’s Due Process rights by not affording him a fair and impartial hearing. The Board’s discipline was not handed down absent an independent finding made by the AHC.

Dr. Albanna’s claim that the Board is biased against him, and therefore is “out to punish him” has no merit. Dr. Albanna’s accusations are not justified by the evidence, and do not overcome the presumption that tribunals are honest and impartial. *See Marler v. Missouri State Bd. of Optometry*, 102 F.3d 1453, 1457 (discussing *Withrow v. Larkin*, U.S. 35, 47 (1975)). Dr. Albanna chooses to compare his discipline to other physicians who are not in similar circumstances, and chooses instead to rely on a blanket statement that the Board has never imposed such harsh discipline on any other physician for conduct amounting to “mere negligence or repeated mere negligence.” Dr. Albanna fails to recognize that the Board Disciplinary Order was based on the Commission Findings, which indicated that Dr. Albanna was subject to discipline for unprofessional conduct, conduct that was or might be harmful to a patient, incompetence, and repeated negligence

based on his treatment of patients S.W. and C.W. Specifically, Dr. Albanna was found to over-diagnose and over-treat patients by performing extensive, risky surgeries that were unwarranted by the diagnostic tests that he had ordered.

While Dr. Albanna claims that the Board can provide no rational basis for its disciplinary action, the rational basis is simply to protect the public from similar actions. Dr. Albanna, a licensee of the Board of Registration for the Healing Arts, was disciplined by the Board for his treatment of patients S.W. and C.W., only after being afforded the right to a fair and impartial hearing by the AHC, after which he was found to be subject to discipline. Based on the AHC's findings, the Board disciplined his license in a manner that was tailored to protect the public from similar actions, and therefore the discipline is justified.

The State Board of Registration for the Healing Arts disciplined Dr. Albanna by placing his medical license on a five (5) year probationary period. (L.F. 88). During this time, before Dr. Albanna is allowed to proceed with any fusion surgeries and/or surgeries involving instrumentation, his patients are required to obtain a second opinion by another neurosurgeon. (L.F. 88). The Board also required any of Dr. Albanna's patients that were to undergo a fusion and/or a surgery involving instrumentation to sign an informed consent form that was designed by the Board for Dr. Albanna to use in his practice. (L.F. 89). The discipline that the Board imposed was based on the Findings of Fact and Conclusions of Law made by the AHC. (L.F. 88). The Board, by statute, may impose discipline on a licensee upon a finding made by the AHC that there is cause for discipline based on violations of Section 334.100.2. *See* 4 C.S.R. 150-7.140(3).

It is established by law that the Board has considerable discretion in fashioning appropriate discipline in licensing cases. *Burgdorf v. Board of Police Comm'rs*, 936 S.W.2d 227, 233 (Mo. App. E.D. 1996); *State Bd. of Registration for the Healing Arts v. Brown*, 121 S.W.3d 234 (Mo. banc. 2003). The Board is authorized under 4 CSR 150-7.140(3) to discipline a licensee under various methods such as censure, suspension, probation or restriction, and for various lengths of time. In this case the Board's discipline serves a legitimate governmental interest, which is simply the protection of the public.

The discipline imposed by the Board is instead a direct response to the findings made by the AHC, and as such is narrowly tailored to protect the public from the exact types of causes for discipline that Dr. Albanna was found to have violated under Sections 334.100.1(4) and (5), RSMo. The AHC found that Dr. Albanna's medical license was subject to discipline due to the fact that he "over-diagnosed and over-treated" patients. Dr. Albanna was further found to be subject to discipline for unprofessional conduct, conduct that was or might have been harmful to his patients, incompetence, and repeated negligence. The AHC found that Dr. Albanna performed risky surgeries on patients where there was no evidence that the surgeries would help those patients. These findings are serious matters, even though Dr. Albanna attempts to reduce the significance of these violations by calling his conduct "mere negligence or even repeated mere negligence." (Dr. Albanna's Substitute Brief, 65).

The Board is charged with protecting the public, and in an attempt to address these egregious violations of the statute, the Board disciplined Dr. Albanna's license by placing

specific requirements on his medical license during the probationary period. These restrictions were an attempt to curtail the danger that Dr. Albanna posed to his patients by addressing the exact problems that the AHC identified. The Board is allowed “broad discretion to impose whatever discipline it [finds] appropriate, so long as that discipline [falls] within the range of discipline permitted for a violation of its code of conduct.” *Burgdorf*, 936 S.W.2d at 233. While Dr. Albanna claims that the Board is attempting to destroy his practice, the discipline imposed falls within the discretion of the Board, and is within the range of discipline allowed by the statutes.

Dr. Albanna contends that the discipline that the Board placed on his medical license was more burdensome than that of many of the other licensees disciplined by the Board in recent years. Furthermore, Dr. Albanna alleges that this proves that his equal protection rights under the 14th Amendment to the Constitution of the United States have been violated. “However, when the treatment at issue does not involve a fundamental right or a suspect classification, it survives an equal protection challenge so long as it bears a rational relationship to a legitimate government interest.” *Artman v. State Bd. of Registration for the Healing Arts*, 918 S.W.2d 247, 252 (Mo. banc. 1996).

In this case, Dr. Albanna has not demonstrated that he was intentionally treated differently than others who are similarly situated without a showing of intent by the Board to apply the law differently with respect to Dr. Albanna as against others licensees. Mere proof that others who were supervised by the Board received lesser “punishment,” without more, does not make out a prima facie case of a denial of equal protection, especially when the others are not similarly situated. *Burgdorf*, 936 S.W.2d at 233-34.

As a matter of law, a board does not have to consider other punishment before imposing discipline, and has broad authority to impose discipline as long as it is within the board's statutory authority. *Id.* In this instance, the Board's discipline falls well within the range authorized by statute, and therefore it is well within the Board's discretion how exactly to discipline Dr. Albanna's license, with the idea that the discipline is serving a legitimate government interest; protecting the public. *See* 4 CSR 150-7.140(3).

The Court of Appeals for the Eastern District previously held that the Missouri State Board of Accountancy did not abuse its discretion by imposing harsher discipline on one licensee than on another. *M.M. v. State Bd. of Accountancy*, 728 S.W.2d 726, 727 (Mo. App. E.D. 1987). In that case the licensee appealed an order revoking his license and presented evidence that the Accountancy Board imposed lesser discipline for conduct that could be possibly construed as more egregious. *Id.* The Court of Appeals noted that the "mere fact that the harshest penalty was imposed here and not in another case, does not, by itself, prove that the Board abused its discretion." *Id.* The Court of Appeals held that the Board of Accountancy's order was supported by "competent and substantial evidence" on the record, as is the Board's discipline in this case. *Id.*

Dr. Albanna has to demonstrate that he was intentionally treated differently from other licensees who are similarly situated and that there is no rational basis for the difference in treatment. In this case, the Board imposed discipline that was clearly within its discretion and its statutory authority. The discipline was tailored to allow Dr. Albanna to continue practicing neurosurgery, while putting in place safeguards that protect the public from the exact conduct that was found to be cause for discipline by the AHC. The

Board did not act in an abusive or discriminatory fashion by imposing discipline on Dr. Albanna's medical license, and the discipline imposed on Dr. Albanna's medical license does not violate his equal protection rights.

CONCLUSION

The Board is authorized by statute to discipline a licensee for violations of Section 334.100.2, RSMo. In this case, the AHC made findings that Dr. Albanna's medical license was subject to discipline for his treatment of patients S.W. and C.W., as represented in the AHC's Findings of Fact and Conclusions of Law, which was entered on December, 27, 2004. The Board disciplined Dr. Albanna's license based on those findings. The AHC's findings were made after carefully considering the testimony and evidence in the record and properly applying Missouri legal standards to the facts in this case. The AHC found cause for discipline on only two (2) of six (6) counts under the Board's First Amended Complaint. The Board met its burden of proof as to those two Counts, and the AHC's findings were supported by competent and substantial evidence.

The Board's discipline of Dr. Albanna was fashioned in a manner so as to protect the public from the types of violations that led to Dr. Albanna's discipline. The Board, in its discretion, imposed discipline that allowed Dr. Albanna to continue to practice neurosurgery, while ensuring that restrictions placed on his practice would protect his patients. The Board's discipline in this matter, which is based on the AHC's findings, was correctly obtained and should be upheld.

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CERTIFICATE OF ATTORNEY

I hereby certify that the foregoing *Appellant's Substitute Brief* complies with the provision of Rule 55.03 and complies with the limitations contained in Rule 84.06(b) and that:

- (I) It contains 20,521 words, as calculated by counsel's word processing programs;
- (II) A copy of this Brief is on the attached 3.5" disk; and that
- (III) The disk has been scanned for viruses by counsel's antivirus program and is free of any viruses.

Brian W. McEachen

Certificate of Service

I hereby certify that a true and correct copy of *Appellant State Board of Registration for the Healing Art's Substitute Brief*, and a copy of the *Appendix* were sent by U.S. Mail, postage paid, this 6th day of April, 2009, to:

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