



**In the
Missouri Court of Appeals
Western District**

MARY LUSCOMBE,)
)
 Appellant,) **WD75049**
)
 v.) **OPINION FILED: January 8, 2013**
)
 MISSOURI STATE BOARD OF)
 NURSING,)
)
 Respondent.)

Appeal from the Circuit Court of Cole County, Missouri
The Honorable Byron L. Kinder, Judge

Before Division Three: Alok Ahuja, Presiding Judge, Victor C. Howard, Judge and
Cynthia L. Martin, Judge

Mary Luscombe ("Luscombe") appeals the Administrative Hearing Commission's ("AHC") decision that found cause for disciplining Luscombe and the Missouri State Board of Nursing's ("Board") decision that terminated her nursing license. Luscombe contends that both the AHC's decision and the Board's decision are not supported by competent and substantial evidence and are arbitrary, capricious, and unreasonable. First, Luscombe argues that the AHC improperly found that she acted with gross negligence because there was no expert testimony presented to establish the standard of care.

Second, Luscombe claims that the AHC erred in finding that she forged patients' signatures, as the AHC refused to admit offered affidavits that included the patients' original signatures, and as the AHC found her to be incompetent and to have engaged in misconduct for failing to submit records without the benefit of expert testimony. Third, Luscombe contends that the Board erred in terminating her nursing license because the testimony and evidence submitted by Luscombe at the hearing before the Board was not refuted.

We affirm in part and reverse and remand in part.

Factual and Procedural Background¹

In 2004, Luscombe began working as a registered nurse ("RN") in the neonatal intensive care unit ("NICU") at Columbia Regional Hospital ("the Hospital"). As an RN in the NICU, Luscombe was assigned to work alongside another nurse in a pod with the capacity for six patients. The patients in the NICU are infants who were born prematurely, have an infection, were born with birth defects, or become sick after birth.

¹Luscombe filed two legal files: one regarding the administrative proceedings and one regarding the appeal to the circuit court. Luscombe's administrative proceedings legal file includes a table of contents, but that table of contents neither complies with the letter nor the spirit of Local Rule XIX. The administrative proceedings record on appeal consists of eight volumes, including four volumes of exhibits entered during the hearing before the AHC. The table of contents generally notes that the transcript from the AHC and the exhibits entered during that hearing are located on pages 1-1069, which are bound and numbered separately. The transcript of proceedings at the AHC is located on pages 1- 469. The remaining 600 pages include the exhibits entered during the AHC proceedings. There is no table of contents identifying each exhibit.

Local Rule XIX requires that the legal file "be paginated and contain a list of the documents included by page number." Because Luscombe's legal file does not identify each exhibit in a table of contents, the legal file does not comply with Local Rule XIX. The pagination and table of contents requirements promote judicial efficiency, a goal frustrated by this appeal. The Court was forced to search extensively for each exhibit necessary to the determination of this case, an outcome that could have been avoided with the inclusion of a detailed table of contents.

Despite Luscombe's failure to comply with Local Rule XIX, we have elected to review the merits of her appeal. *See, e.g., Lewis v. Biegel*, 204 S.W.3d 354, 364 n.10 (Mo. App. W.D. 2006) ("While not condoning non-compliance with the rules, a court will generally, as a matter of discretion, review on the merits where disposition is not hampered by the rule violations." (citing *Doe v. Roman Catholic Diocese of Jefferson City*, 862 S.W.2d 338, 343 (Mo. banc 1993))).

The Hospital's policy required that all NICU patients be monitored for bradycardia and apnea through continuous cardiac monitoring. The policy allowed the cardiac monitors to be temporarily suspended² "only if infant stable or for breastfeeding/bath, etc." Barb Brucks ("Brucks"), the manager of the NICU at the Hospital, testified that when the cardiac monitor is suspended, the nurse must be at the bedside to observe the patient and must not turn his or her back to the patient. In 2005, Brucks sent an e-mail that stated the cardiac monitors were not to be suspended. Luscombe later admitted that she received the e-mail and was confused about the proper protocol but never asked for clarification.

On May 29, 2005, Luscombe worked a twelve-hour shift in the NICU. Luscombe and another RN, Christine Koestner ("Koestner"), worked together in a pod that had six NICU patients. Both Luscombe and Koestner were responsible for three patients, but nurses working in the NICU care for the other nurse's patients during lunch breaks or when the nurse is occupied with another patient. Luscombe assisted Koestner with one of Koestner's patients throughout the day during which the patient's cardiac monitor's alarm sounded several times. More than once, Luscombe suspended the patient's cardiac monitor, turned the screen so that she could see it, and walked away from the patient's bedside. While the cardiac monitor was suspended, the parents of the patient noticed that the patient's heart rate was slower than it should have been. The parents found Luscombe

²Suspending the cardiac monitor silences the alarms for three minutes, but the cardiac monitor's screen continues to display the patient's heart rate and respiratory pattern.

and notified her of the problem so that she could care for the patient. The parents later complained to Brucks about Luscombe's inattention to the patient.

Luscombe was terminated from her position at the Hospital on June 9, 2005, for "[l]ack of critical thinking, subsequent action of suspending the alarms and failure to recognize the critical nature of her decisions." In a handwritten letter to an investigator for the Board, Luscombe admitted to suspending the cardiac monitor, leaving the patient's bedside, and positioning the monitor so that she could see it away from the bedside.

After being terminated from her position at the Hospital, Luscombe began working as a health care provider for Integrity Home Care ("Integrity"). Integrity provides services to Medicaid recipients. As a Medicaid provider, Integrity is responsible for providing adequate documentation of nurse visits. Integrity bills MO HealthNet, the division of the Department of Social Services that administers Missouri's Medicaid program, and pays its nurses for the visits. Luscombe provided nursing services for Integrity's in-home services, private duty nursing, and private pay departments.

At the time of Luscombe's employment with Integrity, the company had an in-home services nursing manual that included several policies to comply with Medicaid documentation requirements. Luscombe signed a statement that she had read and understood the manual and agreed to follow the policies and procedures therein. The manual required Integrity's in-home nurses to complete reports that document the services provided after every visit. The policy specifically stated:

NURSE VISIT REPORT: This form is used for every nursing visit except the initial visit. Fill all blanks with information or write N/A if it is not applicable. Every visit must be signed by the nurse and the client with the client's number on every form. Sign all progress notes written on your nurse visit.

Integrity required "[a]ll nurse visit forms [to be] turned in every week, as they are part of [each nurse's] time slips." Integrity also used a telephone system, Telephony, to track nurse visits with clients. The clients' home phones were connected to Telephony. Upon arriving at a client's home, the nurse would call a 1-800 number to clock into the visit. The nurse would call the same number to clock out of the visit. Integrity billed Medicaid and paid the nurses based on the information in the Telephony system.

Luscombe worked for Integrity until October 17, 2007, when she resigned. At the time of her resignation, Luscombe did not submit all nurse visit reports, as required by Integrity's policies, but Integrity did not realize the extent of the missing documentation until after her departure. Integrity discovered the missing nurse visit reports by comparing the Telephony records for Luscombe's visits to the nurse visit reports in their possession. There were Telephony records that did not have matching nurse visit reports, despite Integrity's policy that the reports be turned in weekly.

In March 2008, Randa Kullman ("Kullman") became Integrity's in-home nurse supervisor and was tasked with obtaining the missing nurse visit reports from Luscombe. Kullman began requesting records from Luscombe in May 2008. Kullman instructed Luscombe that if there were any nurse visit reports with missing client signatures, Luscombe would not be allowed to go to clients' homes to obtain signatures because she was no longer an Integrity employee. On June 6, 2008, Luscombe submitted

documentation for approximately fifty-three nurse visits that took place between January 2007 and August 2007. Luscombe submitted a second set of documentation in August 2008. The second set included approximately 174 nurse visit reports from January to August 2007.

Even after Luscombe submitted the missing nurse visit reports to Integrity, discrepancies between the documentation and the Telephony records existed. For some visits, the Telephony record showed that Luscombe made an in-home visit to the client, but the written documentation indicated that the client was not present for the nurse to complete the visit ("missed visit"). Luscombe had already been paid for these missed visits because Integrity relied on the Telephony records in paying the in-home nurses. Medicaid did not permit reimbursement for missed visits, so Integrity issued Medicaid a refund. At the time of Luscombe's employment, Integrity's policy did not permit payment to in-home nurses for missed visits unless the nurse provided documentation that he or she called the client the prior day to confirm the visit. Thus, Luscombe received compensation to which she was not entitled.

Both the Hospital and Integrity filed complaints regarding Luscombe's actions to the Board. Following an internal investigation, the Board filed a complaint to the AHC that set forth two independent bases for finding cause to discipline Luscombe's license. *See* section 335.066.2³ (allowing the Board to file a complaint setting forth the cause or causes to discipline a nurse's license with the AHC). First, the Board's complaint alleged that Luscombe's repeated suspension of the cardiac alarms in the NICU created cause to

³All statutory references are to RSMo 2000 as supplemented unless otherwise indicated.

discipline her license pursuant to sections 335.066.2(5)⁴ and (12)⁵. Second, the Board's complaint alleged that Luscombe's failure to turn in accurate nurse visit reports on a timely basis created cause to discipline her license pursuant to sections 335.066.2(4),⁶ (5), and (12). Luscombe filed an answer denying the Board's allegations.

Pursuant to section 621.045.1, the AHC held a hearing. In addition to presenting witnesses who testified about the policies of the Hospital and Integrity that nurses must follow, the Board presented the testimony of Don Lock ("Lock"), a forensic consultant who specializes in handwriting analysis, to support its allegation that Luscombe forged the signatures of patients. Lock analyzed the signatures of six patients. He compared the patients' "known" signatures to the patients' "questioned" signatures. The "questioned" signatures were on nurse visit reports that Luscombe submitted after she no longer worked at Integrity. Lock testified that it was "highly probable" that the patients did not sign the nurse visit reports that were not submitted until after Luscombe's employment.

While cross-examining Lock, Luscombe attempted to introduce affidavits from two patients. In the affidavits, the patients identified the "questioned" signatures as their own. The AHC refused to admit the affidavits into evidence because Luscombe did not serve the affidavits on opposing counsel eight days before the hearing. *See* section 536.070(12). During her case-in-chief, Luscombe presented two patients as witnesses,

⁴Section 335.066.2(5) allows for discipline against a nurse's license for "[i]ncompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties" required of the profession.

⁵Section 335.066.2(12) allows for discipline against a nurse's license for the "[v]iolation of any professional trust or confidence."

⁶Section 335.066.2(4) allows for discipline against a nurse's license for "[o]btaining or attempting to obtain any fee, charge, tuition or other compensation by fraud, deception or misrepresentation."

and both testified that their "questioned" signatures were genuine. The other four patients with "questioned" signatures did not testify.

Luscombe testified at the AHC hearing. Luscombe testified that she was aware of the Hospital's policy regarding suspension of the cardiac monitors and admitted that she suspended a patient's cardiac monitor on May 29, 2005, in violation of the Hospital's policy. In addition, Luscombe admitted that she did not timely submit nurse visit reports to Integrity. She explained that her divorce was the cause of the late submission of documents because the nurse visit reports were at her ex-husband's home, to which Luscombe did not have access until after her employment with Integrity ended. When asked about the accuracy of the nurse visit reports that were submitted belatedly, Luscombe denied falsifying nurse visit reports and denied forging client signatures.

After reviewing the evidence presented at the hearing, the AHC issued its findings of fact and conclusions of law, as required by section 621.045.1. First, the AHC concluded that Luscombe's suspension of a patient's cardiac monitor constituted cause for disciplining her license under sections 335.066.2(5) and (12). The AHC found that the Hospital had established that it had protocols and directives in place addressing the suspension of cardiac monitors in the NICU, and that Luscombe's failure to obey hospital protocols and directives constituted gross negligence (section 335.066.2(5)) and a breach of professional trust (section 335.066.2(12)).

Second, the AHC concluded that Luscombe's failure to submit accurate nurse visit reports constituted cause for disciplining her license. The AHC found Lock's testimony and opinion credible and convincing. In contrast, the AHC found Luscombe's testimony

that she did not falsify nurse visit reports and did not forge client signatures incredible. The AHC accepted Lock's opinion unless his opinion was specifically refuted by a witness. Thus, the AHC found that Luscombe signed the names of four patients on nurse visit reports. The AHC concluded that, by forging patients' signatures, Luscombe obtained a fee by fraud, deception, and misrepresentation in violation of section 335.066.2(4).

The AHC also found that Luscombe's explanation for turning in late documents was incredible, based on the timeline of events. Luscombe's divorce was granted and she was allowed to go to her ex-husband's home to collect her belongings before her employment with Integrity ended, requiring the AHC to believe that she stored nurse visit reports at a residence where she was no longer living and to which she had no access after her divorce. The AHC concluded that, because Luscombe failed to submit nurse visit reports timely, she obtained a fee by fraud, deception, and misrepresentation in violation of section 335.066.2(4).

The AHC further found that Luscombe failed to provide Integrity with accurate records of the "missed visits." As a result, Integrity incorrectly billed Medicaid for the services Luscombe reported providing through the Telephony system. The AHC concluded that, because Luscombe failed to provide accurate records on more than one occasion, she acted intentionally. The AHC concluded that Luscombe's failure to keep accurate records of the "missed visits" resulted in Luscombe collecting a fee from Integrity by fraud, deception, and misrepresentation in violation of section 335.066.2(4).

The AHC also concluded that Luscombe's conduct in connection with her recordkeeping while employed at Integrity constituted two additional bases to discipline Luscombe's license. The AHC concluded that Luscombe's failure to properly document her professional visits to patients constituted incompetency and misconduct, a basis for discipline under section 335.066.2(5), and a violation of professional trust, a basis for discipline under section 335.066.2(12).

Following the AHC's decision that concluded there was cause to discipline Luscombe under section 335.066.2(4), (5), and (12), the Board held a hearing to determine the appropriate discipline to impose against Luscombe's license. *See* section 335.066.3. Luscombe appeared in person at the hearing and was represented by counsel. Luscombe presented six witnesses, each of whom testified as to her performance as a nurse and to her character. In addition, Luscombe testified on her own behalf, with members of the Board questioning her about her performance as a nurse for the Hospital and for Integrity. Following the hearing, the Board issued a disciplinary order that revoked Luscombe's nursing license.

Luscombe filed a petition for judicial review and a request for a stay of the administrative decisions in Cole County. The trial court granted the stay. Following briefs and oral arguments by both parties, the trial court entered a judgment affirming the AHC's decision and the Board's decision.

Luscombe appeals.

Standard of Review

Pursuant to section 621.145, the action of the AHC and the action of the Board are treated as a single decision. On appeal from the trial court's review, we review the decision of the AHC and the Board, not the decision of the trial court. *Koetting v. State Bd. of Nursing*, 314 S.W.3d 812, 815 (Mo. App. W.D. 2010). We examine the decision to determine "whether, considering the whole record, there is sufficient competent and substantial evidence to support [it]. This standard would not be met in the rare case where the [decisions are] contrary to the overwhelming weight of the evidence." *Albanna v. State Bd. of Registration for Healing Arts*, 293 S.W.3d 423, 428 (Mo. banc 2009) (quoting *Lagud v. Kansas City Bd. of Police Comm'rs*, 136 S.W.3d 786, 791 (Mo. banc 2004)). In determining whether there was sufficient competent and substantial evidence to support the decisions, we defer to the AHC and the Board for their assessment of witness credibility, but we review issues of law *de novo*. *Koetting*, 314 S.W.3d at 815.

Analysis

Luscombe presents three points on appeal, two of which concern the AHC's decision and one of which concerns the Board's decision. First, Luscombe argues that the AHC erred in concluding that expert testimony was not required to establish the standard of care, an essential element of gross negligence, by which a NICU nurse must adhere. Second, Luscombe contends that the AHC erred in refusing to admit affidavits from two patients into evidence and that the AHC erred in concluding that expert testimony was not required to determine that Luscombe's failure to submit records constituted

incompetency and misconduct.⁷ Third, Luscombe claims that the Board erred in suspending her license because the evidence presented at the disciplinary hearing was not refuted.

Expert Testimony to Establish the Standard of Care for a NICU Nurse (Point One)

In connection with Luscombe's suspension of cardiac monitors while employed at the Hospital, the Board alleged there was cause to discipline Luscombe under Section 335.066.2(5) for:

Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096.

The AHC found "incompetency" to be a "'state of being' showing that a professional is unable or unwilling to function properly in the profession" (quoting *Albanna*, 293 S.W.3d at 435). The AHC found "misconduct" to mean "the willful doing of an act with a wrongful intention; intentional wrongdoing" (citing *Mo. Bd. for Architects, Prof'l Eng'rs & Land Surveyors v. Duncan*, No. AR-84-0239 at 125 (Mo. Admin. Hearing Comm'n Nov. 15, 1985), *aff'd*, 744 S.W.2d 524 (Mo. App. E.D. 1988)). Finally, the AHC found "gross negligence" to be "a deviation from professional standards so egregious that it demonstrates a conscience indifference to a professional duty" (citing *Duncan*, 744 S.W.2d at 533).

⁷Luscombe's second point relied on presents two claims of error, which violates Rule 84.04(d) and preserves nothing for appellate review. *Jeffus v. Jeffus*, 375 S.W.3d 862, 863 n.1 (Mo. App. W.D. 2012). Despite the second point's duality, we exercise our discretion to *ex gratia* address the issues raised in Luscombe's second point relied on.

We will not, however, consider additional claims of error that Luscombe raises in the argument portion of her Brief, but not in the point relied on. "The argument shall be limited to those errors included in the 'Points Relied On.'" Rule 84.04(e). Those arguments not included in the points relied on are not preserved for appeal. *Dep't of Soc. Servs. v. Peace of Mind Adult Day Care Ctr.*, 377 S.W.3d 631, 642 n.14 (Mo. App. W.D. 2012).

The AHC concluded that Luscombe's suspension of a NICU baby's cardiac monitor "displayed a 'conscience indifference to her professional duty' and thus constituted gross negligence rather than misconduct."⁸ Luscombe's conduct found by the AHC to be a "deviation from *professional standards* so egregious that it demonstrate[d] a conscience indifference to a professional duty" was her failure to obey hospital directives or protocols involving the suspension of a NICU baby's cardiac monitor. (Emphasis added.) Thus, the AHC concluded that the "professional standards" from which Luscombe's conduct egregiously deviated were the hospital's "directives or protocols."

The "protocols" referred to by the AHC were both a written protocol and an understood practice. The written protocol provided:

All infants admitted to the NICU are monitored for bradycardia/apnea through continuous cardiac monitoring. . . . Suspend alarms (temporary - 3 minutes) only if infant stable or for breastfeeding/bath, etc. . . . Discontinue use of this protocol when infant is transferred out of the unit, is discharged or when rooming-in with parent(s) prior to discharge.

In addition, Brucks testified that it was understood that the cardiac alarms can be temporarily suspended for three minutes but the nurse must remain at the bedside watching the patient. The AHC found that Luscombe admitted that she was aware of the Hospital's protocol on the subject of suspension of cardiac monitors, a finding Luscombe does not contest on appeal. The "directive" referred to by the AHC was an email sent out by Brucks in late May 2005, directing that NICU cardiac monitors *were not to be*

⁸The AHC did not conclude that Luscombe's suspension of the NICU cardiac monitors constituted incompetency or misconduct.

suspended at all. Luscombe admitted that she received the email and that she did not ask clarification, notwithstanding the email's divergence from the hospital's protocols.

It is difficult to discern from the AHC's Decision whether the AHC concluded Luscombe was grossly negligent because she: (1) suspended the cardiac monitor in violation of the written protocol; and/or (2) suspended the cardiac monitor in violation of the "understood" application of the protocol because she did not remain bedside; and/or (3) suspended the cardiac monitor in violation of the email. The AHC's failure to specify in what precise respect it believed Luscombe failed to obey the Hospital protocol or directives is not challenged by Luscombe. Nor does Luscombe argue that the record as a whole fails to support a finding that one or more of the Hospital's protocols or directives was violated.

Instead, the only issue raised by Luscombe with respect to the AHC's decision that she was subject to discipline for having suspended NICU cardiac monitors is whether the AHC properly found her grossly negligent for suspending the monitors without expert testimony to establish the professional standard by which she was obliged to conform her conduct. In reaching its conclusion that Luscombe was grossly negligent, the AHC acknowledged that "[t]here is no expert testimony about the monitor," but found that "no expert testimony was needed" because it was "capable of concluding that failure to obey hospital directives or protocol may constitute 'indifference to professional duties' without expert testimony." We thus turn our attention to whether expert witness testimony was required to establish the professional standard Luscombe was required to follow, and whether Luscombe's conduct violated that standard of care.

Defining Gross Negligence

"[G]ross negligence' is a term which appears infrequently in appellate decisions of this state" because Missouri "has consistently refused to recognize differing degrees of negligence." *Boyer v. Tilzer*, 831 S.W.2d 695, 697 (Mo. App. E.D. 1992). "The Missouri General Assembly, however, has a 'penchant' to use the term in the area of professional licensing." *Edwards v. Gerstein*, 363 S.W.3d 155, 165 (Mo. App. W.D. 2012) (citing *Boyer*, 831 S.W.2d at 697). "Negligence is defined in Missouri law as the failure to use the degree of care required under particular circumstances involved." *Id.* (quoting *Duncan*, 744 S.W.2d at 532). "The term 'gross negligence,' therefore, 'connotes an improper conduct greater in kind or degree or both in ordinary negligence.'" *Id.* (quoting *Duncan*, 744 S.W.2d at 532).

In a licensing context, this Court's Eastern District accepted a definition of "gross negligence" which requires "an act or course of conduct which demonstrates a conscious indifference to a professional duty." *Boyer*, 831 S.W.2d at 698. The Court in *Boyer* noted that "conscious indifference" does not differ materially from another frequently employed definition of gross negligence which requires "'reckless conduct done with knowledge that there is a strong possibility of harm and indifference as to that likely harm.'" *Id.* at 698. (quoting *Duncan*, 744 S.W.2d at 533). "*Boyer* and *Duncan* instruct that in order to differentiate between . . . [ordinary] negligence, the definition of gross negligence . . . must incorporate language which captures . . . *an elevated mental state* similar to either conscious indifference or reckless conduct done with knowledge of and indifference to the probability of harm." *Gerstein*, 363 S.W.3d at 166 (emphasis added).

The import of *Gerstein, Boyer, and Duncan* is to reinforce that the difference between ordinary negligence and gross negligence turns on a heightened mental state of culpability. Though ordinary negligence and gross negligence differ with respect to the required showing of mental culpability, they do not differ with respect to the evidence required to establish the essential element of a duty owed. When negligence, whether ordinary or gross, is asserted in the performance of professional conduct, "the specific duty is defined by the profession." *Ostrander v. O'Banion*, 152 S.W.3d 333, 338 (Mo. App. W.D. 2004). This "professional standard" is commonly referred to as a standard of care.

Establishing the Standard of Care and Violation Thereof

In this case, the evidence introduced to demonstrate the "professional standard," *i.e.*, the standard of care, Luscombe was purportedly required to follow, was limited to: (1) the Hospital's written protocol, (2) Brucks's testimony about the Hospital's unwritten protocol, and (3) testimony regarding Brucks's email forbidding any suspension of cardiac monitors. The evidence relied upon by the AHC to conclude that Luscombe violated a professional standard (standard of care) was Luscombe's admitted suspension of the cardiac monitors, without regard to whether her explanation for the suspensions was within the standard of care.⁹

The AHC committed legal error. The standard of care applicable to professional conduct cannot be established by a hospital's rules and regulations, and even if it could,

⁹Luscombe testified that she did not intend to harm the baby in suspending the cardiac alarm, and that she did so because the unit was understaffed and the alarm was repeatedly sounding. She also testified that she suspended the alarm to calm the baby's nervous mother.

mere violation of a hospital rule or regulation does not establish a violation of the standard of care without expert testimony regarding whether the factual explanation for the violation is outside the standard of care.

In *Dine v. Williams*, 830 S.W.2d 453, 455-56 (Mo. App. W.D. 1992), a medical malpractice case, a trial court excluded a plaintiff's offer of hospital's rules and regulations that addressed an attending doctor's obligation to supervise resident physicians. *Id.* at 455-56. The defendant attending physicians acknowledged they had an obligation to supervise resident physicians. The hospital's rules and regulations were offered by the plaintiff to establish the "responsibility" of the attending physicians to supervise and not (according to the plaintiff) to establish the standard of care. *Id.* The attending physicians argued that the rules and regulations suggested a duty of supervision that was not itself in a form sufficient to establish a medical standard of care, making admission of the rules and regulations irrelevant and prejudicial. *Id.* The trial court excluded the evidence because it believed the rules and regulations "attempted to establish standard of care by an improper means." *Id.*

We observed that the liability of the attending physicians was predicated on their alleged failure to properly supervise resident physicians. *Id.* As a result, the plaintiff was required to establish a standard of care of the attending physician's duty to supervise other doctors. *Id.* We acknowledged that some jurisdictions have held that a hospital's rules and regulations can be admitted to prove a *hospital's* standard of care but determined that those cases were not applicable because: (1) the rules and regulations involved in those cases did not concern matters of medical knowledge requiring expert

testimony; and (2) the cases dealt with *hospital* (and not individual physician) negligence. *Id.* We concluded that the "standard of care in supervising a resident physician by an attending physician is a technical subject outside the common knowledge and experience of a jury." *Id.* We further concluded that "[e]vidence establishing the standard of care in a medical negligence case *must be introduced by expert testimony.*" *Id.* (citing *Hart v. Steele*, 416 S.W.2d 927 (Mo. 1967)) (emphasis added). The rules and regulations of the hospital dealing with the requirements of attending physicians might have been admissible "if and only when the proper standard of care [had been] proven by expert medical testimony," and even then the admission would have been "to support the negligence conduct" and not to establish the standard of care. *Id.* at 457.

In *Hart v. Steele*, the case favorably cited by *Dine*, the Missouri Supreme Court held a claim of medical negligence requires proof that the medical professional's conduct constitutes a failure to exercise "that degree of care, skill and proficiency which is commonly exercised by the ordinarily careful, skillful and prudent surgeon engaged in similar practice under the same or similar conditions." 416 S.W.2d at 931. The Supreme Court concluded that this element had not been demonstrated because the plaintiff "offered no expert medical testimony on the question whether the act [of the physician] would constitute a failure on the part of the defendant to measure up to the standard of care required of . . . surgeons [in the same field]." *Id.* The Supreme Court further observed that "[i]n the great majority of malpractice cases a submissible case may only be made by expert medical testimony for otherwise a jury may not know (or guess) whether the defendant's acts did or did not conform to the required standards." *Id.*

(internal quotation marks omitted). The only exception to this general rule "is that where the want of skill or lack of care is so apparent as to be within the comprehension of laymen and requires only common knowledge and experience to understand and judge it, expert evidence is not essential." *Id.* at 932 (internal quotation marks omitted). The Supreme Court noted that the only cases that had been decided in Missouri to date that fall within this "exception" are those cases where "a physician or surgeon has left foreign objects in operative cavities." *Id.* In such cases, "proof of such fact alone is generally held to establish a prima facie case of negligence." *Id.*

The pronouncement in *Hart* with regard to the requirement of expert testimony to establish the standard of care has not been reversed, modified, or limited by any subsequent Missouri Supreme Court decision. In fact, the principle has been oft-repeated in subsequent cases in Missouri. *See, e.g., Langton v. Brown*, 591 S.W.2d 84, 88 (Mo. App. W.D. 1980) (holding that to establish the standard of care in a case involving "medical treatment beyond the scope of laymen, plaintiff carries the burden of proving such by expert testimony"); *Ladish v. Gordon*, 879 S.W.2d 623, 628 (Mo. App. W.D. 1994) ("Expert testimony generally must be introduced to establish the standard of care in a medical negligence case."); *Newland v. Azan*, 957 S.W.2d 377, 378 (Mo. App. W.D. 1997) ("Expert testimony generally must be introduced to establish the standard of care in a medical negligence case."); *Ostrander*, 152 S.W.3d at 338 ("In professional negligence cases . . . the specific duty is defined by the profession, itself. That is, an expert witness is generally necessary to tell the jury what the defendant should or should not have done under the particular circumstances of the case and whether the doing of that act or the

failure to do that act violated the standards of care of the profession"); *McLaughlin v. Griffith*, 220 S.W.3d 319, 320 (Mo. App. S.D. 2007) ("[S]tandard of care generally must be established by expert testimony.")¹⁰.

There is no dispute that the same requirements apply to establishing standard of care in professional licensing cases as apply in traditional professional negligence cases. In response to an argument that expert testimony on the standard of care was not necessary in a case involving discipline of a physician's license, our Supreme Court held that where a "case deals with complex issues as to the appropriate medical care for patients . . . , a matter not within lay competence, expert testimony [is] necessary to determine what standard of care was required of [the professional] and whether he met that standard of care." *State Bd. of Registration for the Healing Arts v. McDonagh*, 123 S.W.3d 146, 158 n.16 (Mo. banc 2003).

Here, as in *Dine*, the AHC determined the standard of care without the benefit of expert testimony. Instead, the AHC relied exclusively on the Hospital's protocol (both written and as understood) and an email directive to establish the standard of care to which Luscombe was bound to adhere. Unless the exception to the general rule applies, the AHC's determination of the standard of care in the absence of expert testimony is legally erroneous.

¹⁰In *McLaughlin*, the Southern District acknowledged that in cases "where the skill or technique at issue is within general lay knowledge," no expert testimony is required to establish the standard of care. 220 S.W.3d at 322. However, the court also observed that this exception is most often applied in cases where a surgeon leaves a sponge in the body. *Id.* at 323. The court went on to note that "[t]his exception is tightly circumscribed, lest lay jurors establish arbitrary standards on matters beyond their common experience and knowledge, and decide crucial issues on speculation, conjecture, and surmise." *Id.*

The AHC took the position that the professional standard applicable to nurses working in the NICU and relating to the suspension of cardiac monitors was not complex, and thus that the issues before it were not "comparable to the standards for vascular disease treatment or neurosurgery, as was the case in *McDonagh*." We believe the AHC's strained reading of *McDonagh* is in error. Except in those cases involving sponges left in operating cavities, we are not aware of a case in the Missouri in which the standard of care for performance of professional duties has been established without the benefit of expert testimony. In any event, we do not believe that the subject of cardiac monitors generally, let alone the medical circumstances wherein the alarms on infant cardiac monitors may be permissibly suspended within the standard of care, is a matter within the ordinary knowledge of a lay person.

The AHC also found that it was capable without expert testimony "of concluding that failing to obey hospital directives or protocol may constitute 'indifference to professional duties' without expert testimony." In addition to erroneously presupposing that the Hospital's directives and protocols establish a standard of care, the AHC's finding erroneously presupposes that a professional's mere failure to comport with an accepted practice or procedure is self-proving that the professional violated the standard of care. As to this subject, it is clear expert testimony is required. *McDonagh*, 123 S.W.3d at 159 n.16 ("[E]xpert testimony [is] necessary to determine what standard of care was required . . . **and whether [the professional] met that standard of care.**") (emphasis added); see also *Hart*, 416 S.W.2d at 931 (holding that expert testimony is almost always necessary to establish whether or not the professional's actions met the applicable standard of care).

We thus conclude that the AHC had no basis on this record to determine the standard of care applicable to the suspension of cardiac monitors or to determine whether Luscombe's suspension of the cardiac monitors under the circumstances she described violated that unestablished standard of care.

Our conclusion is consistent with the recent decisions in *Tendai v. Missouri State Board of Registration for the Healing Arts*, 161 S.W.3d 358 (Mo. banc 2005), *overruled on other grounds by Albanna*, 293 S.W.3d 423, and *Kerwin v. Missouri Dental Board*, 375 S.W.3d 219 (Mo. App. W.D. 2012). In *Tendai*, a disciplinary proceeding involving a physician, the Missouri Supreme Court noted that "[t]he first step in determining whether gross negligence exists is to determine the applicable standard of care for ordinary negligence." 161 S.W.3d at 367. "When the standard of care involves matters outside the competence and understanding of ordinary lay witnesses, it must be established by expert testimony." *Id.* The Court found that "[n]ot every deviation from a profession's standard of care is gross negligence." *Id.* Rather, to demonstrate gross negligence, it must be shown that a deviation from the applicable standard of care was a result of "conscious indifference to [the professional's] professional duty or otherwise grossly violated the standard of care." *Id.* The Court concluded that "[e]xpert testimony is needed to establish this point, since it is beyond the purview of the ordinary lay witnesses." *Id.* at 368. In short, the Supreme Court in *Tendai* simply reiterated what it had already held in *McDonagh*: with rare exception, expert testimony is required not only to establish the standard of care, but also to establish that the conduct of the professional violated that standard of care. The same conclusion was reached in *Kerwin*. 375 S.W.3d

at 226 ("To demonstrate that a medical professional has committed gross negligence, there must be evidence that the individual engaged in a gross deviation from the standard of care. 'Expert testimony is needed to establish this point, since it is beyond the purview of ordinary lay witnesses.'" (quoting *Tendai*, 161 S.W.3d at 368) (citations omitted)).

In the proceedings before the AHC, the Board contended that Luscombe's case is similar to *Perez v. Missouri State Board of Registration for the Healing Arts*, 803 S.W.2d 160 (Mo. App. W.D. 1991), which held that no expert testimony was needed to establish that a physician's conduct was "unprofessional." The AHC agreed that *Perez* was controlling. We disagree. *Perez* did not involve gross negligence, so no determination of a professional standard of care, or of whether conduct violated a professional standard of care, was necessary. Rather, *Perez* involved a physician who took advantage of a vulnerable patient seeking fertility assistance by having a sexual relationship with her. *Id.* at 162-163. That type of behavior is outside the "professional duties" of a physician and is not subject to measure against a standard of care. *Perez* is easily distinguishable and has no bearing on the resolution of Luscombe's case, which turned on whether her suspension of NICU cardiac monitors -- the operation of which clearly fell within her recognized professional duties--violated a standard of care.

Our conclusion is also not inconsistent with the Missouri Supreme Court's recent pronouncement in *Stone v. Missouri Department of Health & Senior Services*, 350 S.W.3d 14 (Mo. banc 2011). In that case, the Missouri Supreme Court held that expert witness testimony is not essential to establish causation between a medical professional's conduct and the claimed injury or harm suffered by a patient. *Id.* at 22. The Court found

that a lay person could easily conclude, without the requirement of expert testimony, that a nurse's conduct in forcing a patient to take medications against her will could cause emotional harm. *Id.* *Stone* is not inconsistent with *Hart* and its litany, all of which address the establishment of the professional duty owed and whether that duty was breached, not the distinct and wholly independent element of causation between breach of a duty and injury suffered by a patient.

We conclude that the AHC erroneously found that Luscombe was grossly negligent in violation of section 335.066.2(5) when there was no expert testimony presented to establish the professional standard (the standard of care) for suspension of NICU cardiac monitors in the NICU, or to establish that Luscombe's suspension of cardiac monitors in the circumstances of this case egregiously violated that standard of care.

We acknowledge that the AHC also concluded that Luscombe's failure to obey hospital protocols and directives regarding suspension of cardiac monitors subjected her to discipline because the conduct constituted a "violation of . . . professional trust or conduct." Section 335.066.2(12). The AHC defined "professional trust" as "the reliance on the special knowledge and skills that professional licensure evidences" (citing *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943)). Under the facts and circumstances of this case, the AHC's conclusion is nothing more than a recast of its finding of gross negligence. We conclude that when a violation of professional trust is dependent upon proof of "special knowledge and skills" that are indistinguishable from the professional standards/standard of care necessary to establish "gross negligence," then

said "special knowledge and skills," and the fact that deviation therefrom violates "professional trust," must be established by expert testimony. Accordingly, the AHC erroneously found that section 335.066.2(12) was cause for disciplining Luscombe's license.

Refusal to Admit Affidavits into Evidence (Point Two)

In her second point relied on, Luscombe argues that the AHC erred in refusing to admit two patients' affidavits into evidence. Luscombe claims that the affidavits included original, notarized signatures by the patients and that those original signatures would have assisted Lock in his handwriting analysis. In addition, Luscombe argues that because the patients were homebound due to their medical conditions, admission of their affidavits was the only avenue for the AHC to consider their testimony.

When Luscombe attempted to enter the patients' affidavits into evidence, the Board objected. The Board argued that because Luscombe failed to serve the affidavits on opposing counsel at least eight days before the hearing pursuant to section 536.070(12), the Board had the right to object to the affidavits at the hearing. The Board's counsel did not explain the basis of its objection beyond Luscombe's failure to serve the affidavits timely. The AHC indicated that it sustained the objection because the Board was "entitled to have [the affiants] present and have the opportunity to cross-examination [sic]." While the AHC did not clearly articulate its reasoning for excluding the affidavits, its reference to the opportunity to cross-examine the affiant indicates that the affidavits were excluded as inadmissible hearsay. *See, e.g., Saint Louis Univ. v. Geary*, 321 S.W.3d 282, 291 (Mo. banc 2009) ("Hearsay evidence is objectionable

because the person who makes the statement offered is not under oath and is not subject to cross-examination.").

The decision to exclude evidence is a matter of the AHC's discretion, which we review for abuse of discretion. *Mo. Bd. of Nursing Home Adm'rs v. Stephens*, 106 S.W.3d 524, 527-28 (Mo. App. W.D. 2003). The AHC is not required to follow the technical rules of evidence in its hearings, but the "fundamental rules of evidence" applicable in civil cases are also applicable in AHC hearings. *Stone*, 350 S.W.3d at 21. As such, hearsay "'do[es] not qualify as competent and substantial evidence' to support an agency's decision, 'when proper objection is made and preserved.'" *Dorman v. State Bd. of Registration for Healing Arts*, 62 S.W.3d 446, 454 (Mo. App. W.D. 2001) (quoting *Concord Publ'g House, Inc. v. Dir. of Revenue*, 916 S.W.2d 186, 195 (Mo. banc 1996)). If an objection is not made, though, the AHC may receive and consider hearsay testimony. *Id.*

Section 536.070(12) provides for the admission of affidavits during hearings in contested cases. The admission of affidavits is limited, though:

[I]f such affidavit shall have been served less than eight days before the hearing such objection may be served at any time before the hearing or may be made orally at the hearing. If such objection is so served, the affidavit or the part thereof to which objection was made, may not be used except in ways that would have been permissible in the absence of this subdivision . . .

Section 536.070(12). Thus, in order for the affidavit to be admitted into evidence over an objection, there must be an applicable hearsay exception. *Homa v. Carthage R-IX Sch. Dist.*, 345 S.W.3d 266, 282 (Mo. App. S.D. 2011). Luscombe, either at the AHC hearing

or during the appeal therefrom, has not argued that a hearsay exception applied to allow the affidavits to be admitted into evidence over the Board's objection. As such, we do not find that the AHC abused its discretion in sustaining the Board's objection to the patients' affidavits.

Even if we were to find that the AHC abused its discretion, the exclusion of the patients' affidavits would not constitute prejudicial error. Lock testified that his policy, as a forensic consultant who specializes in handwriting analysis, was not to examine documents on the witness stand. Lock explained that handwriting analysis requires "proper time, proper lighting, and proper equipment," none of which would have been available during the AHC hearing. As such, admitting the patients' affidavits would not have changed Lock's opinion that it was "highly probable" that the patients did not sign the nurse visit reports in question.

Further, if the AHC would have admitted the patients' affidavits for their substance and found that the "questioned" signatures of those patients were not forged, the AHC still would have found that Luscombe forged the signatures of two additional patients. The AHC explicitly "accept[ed] the expert's testimony and opinion unless it was rebutted by evidence other than Luscombe's testimony." Because there were two patients who neither testified nor created an affidavit, the AHC would have accepted Lock's testimony and opinion to find that Luscombe forged the signatures of two patients. Accordingly, if we were to find that the AHC abused its discretion in excluding the patients' affidavits, its conclusions that Luscombe forged clients' signatures and obtained a fee by fraud, deception, and misrepresentation would remain.

Expert Testimony to Establish Incompetency and Misconduct for Failure to Submit Records (Point Two)

Luscombe's second point relied on also argues that the AHC erred in concluding that expert testimony was not required to establish that Luscombe's failure to submit records constituted incompetency and misconduct. Luscombe's position is that a standard of care established by expert testimony is an essential element of incompetence and misconduct in professional licensure discipline cases. Thus, according to Luscombe, the AHC erred in concluding that Luscombe was incompetent and engaged in misconduct in violation of section 335.066.2(5) without hearing expert testimony.

Luscombe has not provided citation to authority that supports her position. Further, our research has yielded no support for Luscombe's position.

As discussed *supra*, establishment of the standard of care is essential to proving gross negligence because "gross negligence" is defined as an egregious deviation from professional standards. *Duncan*, 744 S.W.2d at 533. In contrast, "misconduct" is defined as "the willful doing of an act with a wrongful intention." *Id.* at 541. Nothing in the definition of "misconduct" suggests the need to establish "professional standards" requiring expert testimony in order to prove misconduct. "Incompetency" is defined as a "state of being showing that a professional is unable or unwilling to function properly in the profession." *Albanna*, 293 S.W.3d at 435. Arguably, where "proper function" relates to the provision of medical care, a strong case could be made for requiring expert witness

testimony to establish proper function in the profession.¹¹ However, where "proper function" relates to the generation, creation, or submission of records *not* in connection with patient care issues,¹² but merely to permit proper compensation of the licensed professional and proper reimbursement of the licensee's employer, we do not believe expert testimony is required, as the issue of "standard of care" in performing professional duties is not at issue. The AHC's finding with respect to Luscombe's "incompetence" and "misconduct" in failing to timely submit required records did not require expert testimony.

Suspension of Luscombe's License (Point Three)

In light of our conclusion that expert testimony was required to establish the standard of care by which a NICU nurse must abide, we need not reach Luscombe's third point relied on which questioned the Board's decision to suspend the license. *See Tadrus v. Mo. Bd. of Pharmacy*, 849 S.W.2d 222, 228 (Mo. App. W.D. 1993) (concluding that because the court found one of the AHC's findings with respect to a basis for discipline to be in error, the case must be remanded to the Board of Pharmacy for reconsideration of the sanctions imposed).

Conclusion

The decision is affirmed in part and reversed in part. We remand the case to the Board for reconsideration of the sanction to be imposed on Luscombe's nursing license based solely on the AHC's finding that there is cause to discipline Luscombe's license

¹¹In fact, with respect to Luscombe's suspension of the cardiac monitors, conduct involving the express provision of medical care, the AHC acknowledged as much as it noted in its Decision that "we might require expert testimony to find incompetence for this conduct."

¹²*Cf. McDonagh*, 123 S.W.3d at 159-60.

pursuant to sections 335.066.2(4), (5), and (12) in connection with Count II of the Board's complaint addressing Luscombe's conduct while employed with Integrity.

Cynthia L. Martin, Judge

All concur