

Summary of SC89809, Faisal J. Albanna, M.D. v. State Board of Registration for the Healing Arts

Appeal from the Cole County circuit court, Judge Richard G. Callahan

Attorneys: The board was represented by Glenn E. Bradford and Brian W. McEachen of Glenn E. Bradford & Associates P.C. in Kansas City, (816) 283-0400. Albanna was represented by James B. Deutsch and Thomas R. Schwarz Jr. of Blitz, Bardgett & Deutsch L.C. in Jefferson City, (573) 634-2500; and J. Thaddeus Eckenrode and Mark D. Schoon of Eckenrode-Maupin in St. Louis, (314) 726-6670.

This summary is not part of the opinion of the Court. It has been prepared by the communications counsel for the convenience of the reader. It neither has been reviewed nor approved by the Supreme Court and should not be quoted or cited.

Overview: A neurosurgeon appeals the licensing board's discipline of his medical license based on the Administrative Hearing Commission's findings that he was guilty of unprofessional conduct, repeated negligence and incompetence. In a unanimous decision written by Judge Michael A. Wolff, the Supreme Court of Missouri affirms the commission's decision in part, reverses it in part and remands (sends back) the case so the licensing board may reconsider the discipline to be imposed. The evidence supports the commission's findings that, as to his treatment of two patients, the neurosurgeon was guilty of unprofessional conduct, repeated negligence, and conduct or practice that caused actual or potential harm to a patient. The evidence does not support the commission's finding, however, that the doctor was subject to discipline for incompetence. An evaluation of incompetence requires a finding of more than repeated violations of the standard of care but also must take into account the doctor's capacities and successes. Because the doctor may not be disciplined for incompetence, the licensing board must reconsider what discipline is appropriate for his unprofessional conduct and repeated negligence.

Facts: Based on complaints filed by six patients against Dr. Faisal Albanna, a neurosurgeon who has been practicing in Missouri since 1987, the Missouri Board of Registration for the Healing Arts instituted a disciplinary action against Albanna's license in the Administrative Hearing Commission, alleging negligence constituting unprofessional conduct in violation of section 334.100.2(4) and (5), RSMo 2000. The commission sustained the board's charges as to two patients and rejected its charges as to the other four.

Patient SW came to Albanna in 1996 complaining of neck problems causing severe pain and interfering with her ability to work. After SW responded poorly to the traction treatment that Albanna initially recommended, he ordered additional tests and diagnosed SW with spinal stenosis, a condition in which the spinal cord narrows, pinching spinal nerves. He told her she had three options: live with the pain; continue the more

conservative therapy of traction; or undergo surgery to fuse her cervical vertebrae and to excise part of one vertebra. She had Albanna perform the surgery but later sought a second opinion from another doctor who told her the surgery had been unnecessary. The commission determined that Albanna performed an inappropriate operation on SW, that his conduct amounted to negligence, and that his conduct was unprofessional and might be harmful to a patient.

Patient CW came to Albanna in 1998 after injuring himself while on his construction job, complaining of pain in his legs and back. After conducting a physical examination and ordering certain tests, Albanna diagnosed CW with disc herniation, mild and moderate disc degeneration, and a mild bulge and recommended surgery. During CW's surgery to fuse certain of his lumbar vertebrae, Albanna removed the back of CW's spine to move nerves out of the way (a procedure called a "laminectomy"), filled hollow metal screws (called "cages") with bone material from the portion of CW's spine that Albanna had removed, and inserted the cages into the disk space in front of CW's spine to hold the vertebrae in place until the bone could fuse. Although he did not advise CW that he would do so, Albanna also used a substance called Pro Osteon, which was approved for use in bone fractures but had not been approved yet for use in surgical fusions. After surgery, CW complained of burning pain in his leg and occasional numbness and tingling. X-rays taken in late October 1998 showed that the bone had failed to fuse and that the left cage had migrated, pushing on spinal nerves and probably causing the pain. During CW's corrective surgery in March 1999, another surgeon removed the left cage and performed a bone fusion. The commission determined that, as to CW, Albanna's conduct violated the standard of care, was harmful to the patient's health and was unprofessional. Among its findings were that Albanna should have ordered additional diagnostic procedures before operating on CW, performed a simpler "discectomy" procedure rather than the fusion surgery, and obtained CW's informed consent before using Pro Osteon off-label; used a surgical technique that destabilized CW's spine and contributed to the fusion's failure; failed to recognize and correct the failed bone fusion; failed to document the full extent of the operation; and misrepresented that CW's fusion was progressing when, in fact, there was no fusion. The commission determined that the board could discipline Albanna's license for unprofessional conduct, repeated negligence and incompetence.

On the basis of the commission's decision as to Albanna's treatment of SW and CW, the board placed Albanna's license on probation for five years, during which it will require Albanna to obtain extensive informed consent from his surgical patients and to refer them for second opinions prior to performing surgery. Albanna sought judicial review in the circuit court, which reversed the commission's decision finding grounds for discipline. The board appeals.

AFFIRMED IN PART; REVERSED IN PART; REMANDED.

Court en banc holds: (1) On appeal from the circuit court’s review of an agency decision, this Court reviews the agency’s action but acts on the circuit court’s judgment. In so doing, this Court does not review the evidence in the light most favorable to the agency’s findings. Rather, the standard of review for administrative decisions governed by article V, section 18 of the Missouri Constitution – which includes cases before the healing arts board – is that articulated in *Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220, 223 (Mo. banc 2003): whether there is sufficient competent and substantial evidence, based on the whole record, to support the agency’s decision. To the extent that *Mendelsohn v. State Board of Registration for the Healing Arts*, 3 S.W.3d 783 (Mo. banc 1999), and *Tendai v. Missouri State Board of Registration for Healing Arts*, 161 S.W.3d 358 (Mo. banc 2005), suggest otherwise as to the standard of review, they are overruled.

(2) The evidence in the record as a whole supports the commission’s finding, under section 334.100.2(4), that Albanna engaged in unprofessional conduct. The statute permits the commission to use evidence that Albanna violated the standards of the profession, including expert testimony about the medical facts and opinions as to care, to conclude whether the conduct was unprofessional; the experts need not have testified whether they viewed Albanna’s conduct as unprofessional. Here, “unprofessional conduct” refers first to the wide range of conduct covered by the 17 grounds specified in subparagraphs (a) through (q) of section 334.100.2(4), and it is not within this Court’s purview to speculate as to which of these grounds the board may have had in mind. Albanna’s failure to recognize the failed bone fusion and misleading of CW falls under some of those grounds, providing a basis for finding unprofessional conduct.

(3) The evidence supports the commission’s finding of repeated negligence based on Albanna’s conduct falling below the standard of care.

(a) In section 334.100.2(5), each term – “incompetency,” “gross negligence” and “repeated negligence” – is given its own individual meaning. Otherwise, the use of all three terms would be superfluous. Further, the statute specifically explains: “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.” Here, the commission found more than one occasion on which Albanna’s conduct fell below the standard of care. As to SW, the commission found that Albanna used a surgery that was riskier than that appropriate. As to CW, the commission found that Albanna destabilized CW’s spine; noted in CW’s record that the bone was fusing properly when it was not; and failed to differentiate muscular and disk pain, to seek additional diagnostic tests, to get CW’s informed consent to the off-label use of Pro Osteon, to recognize the bone had not fused properly and to document the full extent of the operation. Even if Albanna’s treatment of CW were viewed as a “continuing treatment” case rather than as individually negligent acts, Albanna’s negligence in

the treatment of both CW and SW rises to the level of a failure to adhere to the standard of care on more than one occasion. These repeated departures – involving more than one patient, with each departure a discrete decision and resulting act – constitute “repeated negligence” within the meaning of the statute’s description of that term.

(b) The commission’s finding of repeated negligence is not obviated by the medical judgment rule, which addresses situations in which there is room for an honest difference of opinion among competent physicians, because the scope of review is to determine whether sufficient evidence supports the commission’s findings. As to SW, one expert was unequivocal in his statement that the surgery was unwarranted, and even Albanna’s expert testified the surgery was more substantial than what the expert would have performed. As to CW, the commission found more persuasive the testimony of the board’s expert – who testified that further testing was warranted to determine whether CW suffered from muscular or disk pain, that the fusion was unnecessary, and that a less extensive “diskectomy” would have been sufficient – than that of Albanna’s experts. As to other aspects of Albanna’s treatment, such as to his failure to get CW’s informed consent for off-label use of a drug, there was no dispute that Albanna’s conduct fell below the standard of care.

(4) The evidence supports the commission’s conclusion that Albanna’s conduct caused and involved actual or potential harm. The commission’s findings rely on section 334.100.2(5), which proscribes “conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public.” There is no need for evidence of “quackery” to support a finding of harm, especially given that the board did not charge Albanna under section 334.100.2(3), the so-called “quackery” statute. Reading “harm” in section 334.100.2(5) in context of nearby words and, indeed, the entire subparagraph, the word “unreasonable” is implicit in the statutory language, such that the board may sanction any conduct that is or might be unreasonably harmful or dangerous to the health of a patient. Without such an implicit inference, any neurosurgeon could be disciplined simply for practicing neurosurgery – which, whether practiced skillfully or negligently, by its very nature is conduct or practice that may be harmful to a patient. The harm the statute seeks to avoid is harm that flows from incompetence, gross negligence or repeated negligence. Because the commission’s findings support the conclusion that Albanna’s conduct involved repeated negligence, the evidence also supports the commission’s conclusion that Albanna’s conduct involved actual or potential harm.

(5) The evidence does not support the commission’s finding that Albanna was subject to discipline for incompetence under section 334.100.2(5). The commission improperly defined “incompetence” as “a general lack of, or a lack of disposition to use, a professional ability.” This Court rejected such a definition in *Tendai*, explaining: “‘Incompetency’ refers to a state of being. ... A doctor who is generally competent could

commit gross negligence or repeated negligence; thus, ‘incompetency’ must mean something different from these other terms.” 161 S.W.3d at 369. Repeated violations of the standard of care constitute repeated negligence, but in themselves, they do not constitute sufficient evidence to prove incompetency. An evaluation of incompetency necessitates a broader-scale analysis, taking into account the doctor’s capacities and successes. Here, there was ample evidence of Albanna’s successful surgeries in extremely difficult and complex cases. Further, the commission sustained the board’s allegations of misconduct only as to patients SW and CW, and as to SW, the commission explicitly found there was no cause to discipline Albanna for incompetency. Although he may have been guilty of repeated violations of the standard of care, there is insufficient evidence on the record that Albanna was incompetent.

(6) Although the record does not support Albanna’s allegation that the board disciplined him more harshly because of his Iraqi national origin, given that the board’s decision to place Albanna on probation for five years – requiring explicit informed consent from his surgical patients and second opinions – seems proportionate to the commission’s correct findings of unprofessional conduct and repeated negligence. Because the commission’s finding of incompetence is reversed, however, it is appropriate for the board to reconsider its discipline accordingly.