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Authorities Relied On

Bever v. State Board 0f Registration for the Healing Arts,

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Authorities Relied On

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844 S.W.2d 16, 19 (Mo.App.W.D. 1992)

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POINT I

I. THE ADMINISTRATIVE HEARING COMMISSION ("COMMISSION") ERRED IN ITS DECISION THAT DR. TENDAI'S MEDICAL LICENSE IS SUBJECT TO DISCIPLINE FOR INCOMPETENCY, GROSS NEGLIGENCE, CONDUCT HARMFUL TO A PATIENT, AND REPEATED NEGLIGENCE BECAUSE SECTION 334.100.2(5) RSMO. IS UNCONSTITUTIONALLY VAGUE AND, AS APPLIED BY THE COMMISSION, VIOLATES DR. TENDAI'S RIGHTS TO PROCEDURAL DUE PROCESS IN THAT THESE TERMS ARE UNDEFINED OR INADEQUATELY DEFINED, ARE NOT TERMS OF GENERAL KNOWLEDGE OR UNDERSTANDING, AND PROVIDED DR. TENDAI WITH NO OBJECTIVE GUIDELINES OR STANDARDS FOR AVOIDING THE PROHIBITED CONDUCT AS DETERMINED BY THE COMMISSION.

The Board of Healing Arts ("Board") erroneously cites *State of Missouri, ex rel., Hurwitz v. North*, 271 U.S. 40, 46 S.Ct. 384, 385, 70 L.Ed. 818 (1926) for the proposition that the United States Supreme Court held early on that Section 334.100.2(5) "is not generally a denial of equal protection of the laws or due process. Board Brief at 15. In *Hurwitz*, the Court reviewed Section 7336, Mo. Rev. Stat. (1919) (which bears little resemblance to Section 334.100.2(5)) and concluded that a physician who performed a criminal abortion, which was specifically prescribed by the statute, was not denied procedural due process or equal protection simply because the Board of Health was not authorized by statute to subpoena witnesses to appear before the Board of Health. *Hurwitz*, 271 U.S. at 42-43. The Court found

that the physician received adequate notice of the hearing, was authorized to present live testimony or testimony of witnesses taken by deposition. *Id*. at 42. Furthermore, even though the Board of Health was not authorized to subpoena witnesses, the physician could have compelled witnesses to testify by deposition. *Id*. at 42. Consequently, under the circumstances presented in that case, where the physician had violated a specific prohibition against performing a criminal abortion, the Court concluded that Missouri's statute did not deny that physician procedural due process or equal protection. *Id*. at 42-43. The Court did not address any claim that the statute was void for vagueness. Consequently, *Hurwitz* does not provide any guidance on the issues presented by Dr. Tendai.

The Board also cites *Bever v. State Board 0f Registration for the Healing Arts*, No. W.D. 57880, 2001 Mo. App. Lexis 148 (Mo. App. W.D. Jan. 30, 2001). See Appendix 1 hereto. As noted by counsel for the Board in its footnote 3, *Bever* was settled after transfer to this Court and, as such, has questionable, if any, precedential value. Nonetheless, since the Board placed this case before the Court, Dr. Tendai will address its factual basis and holdings.[1]

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[1] The Board erroneously claims that Dr. Tendai asserted that the terms "incompetence" and "gross negligence" have not been applied in a physician discipline case under Section 334.100. Board Brief at 18. To the contrary, in footnote 7 on page 53 of Dr. Tendai's Brief, after quoting the definitions of gross negligence and incompetence found in *Duncan v. Bd. for Architects, Professional Eng'rs. And Land Surveyors*, 744 S.W.2d 524 (Mo. App. E.D. 1988), and *Forbes v. Missouri Real Estate Comm'n*., 798 S.W.2d 227, 230

(Mo. App. W.D. 1990), counsel for Dr. Tendai stated the following: "There are apparently no reported opinions defining these terms in the context of professional discipline under Chapter 334, RSMo. " *Bever*, which was dismissed after transfer to this Court, will apparently not be reported by West. Nonetheless, Dr. Tendai will address *Bever,* even though it may have no precedential value.

The Administrative Hearing Commission ("Commission") found cause to discipline Dr. Bever based upon his treatment of three obstetric patients. *Bever*, at *6-9. Appendix 1 at A7-A9. More specifically, the Commission found that Dr. Bever: overestimated the term of Linda's pregnancy and, as a result, the baby was surgically delivered prematurely and suffered respiratory distress syndrome; failed to monitor appropriately Robin, resulting in the premature birth of her son, at twenty-nine weeks, who died six days later; and, caused Tina to suffer cervical lacerations, vaginal lacerations, and a fourth degree peritoneal laceration by his use of forceps, and failed to repair adequately Tina's lacerations, requiring Tina to receive thirty-nine units of blood, resulting in the onset of pulmonary edema and respiratory distress syndrome. *Id*.

The *Bever* court did cite the definitions of incompetence and gross negligence found in *Forbes* and *Duncan*, respectively, *Bever*, at *8. Appendix 1 at A-8. However, the court did not address any claim concerning Dr. Bever's alleged gross negligence. Consequently, any reference therein to the definition of "gross negligence" was *dicta*.

The Board correctly observed that the *Bever* court adopted the Commission's definition of incompetence as "a general lack of, or a general lack of disposition to use, a professional ability." *Bever*, at *24. Appendix 1 at A-13. However, after reviewing the facts, the *Bever* court concluded that the record before the Commission did not demonstrate his incompetence, with the following:

> "The Board did prove two acts of negligence. Just that proof, and particularly on different theories of negligence, is not sufficient, without more, to prove

> incompetence. Nevertheless, we must still consider whether there is otherwise substantial competent evidence that Bever either lacked a professional ability or a general disposition to use that ability. Thus, we first examine the record to see if there was evidence that Bever lacked certain professional skills or abilities in contrast to failing to properly use those skills with a particular patient. We find no such evidence in the record. There remains a final inquiry based on the definition used by the AHC. Is there evidence that the doctor, although possessed of necessary skills and abilities, simply lacked the disposition or will to use those skills? Again we find no such evidence in the record. We, therefore, find that the record does not support the findings of the AHC that Bever demonstrated incompetence."

(Footnotes omitted). *Bever* at *24-25. Appendix 1 at A-13,14. In arriving at its decision, the court was apparently persuaded by the Maine Supreme Court's decision in *Board of Dental Examiners v. Brown*, 448 A.2d 881, 883 (Me. 1982), which found incompetence of a dentist "based on acts of negligence with five patients that the court characterized as a pattern." *Bever*, at *23. Appendix 1 at A-13.

Based upon the foregoing, even though the Court of Appeals applied the Commission's definition of incompetence in a physician discipline case, that case was rendered moot; and, a similar application of that definition to the facts in this case compels the conclusion that Dr. Tendai's treatment of one patient does not demonstrate incompetence.

POINT II

II. THE ADMINISTRATIVE HEARING COMMISSION ("COMMISSION") ERRED IN ITS DECISION THAT DR. TENDAI'S LICENSE IS SUBJECT TO DISCIPLINE FOR INCOMPETENCY, GROSS NEGLIGENCE, CONDUCT HARMFUL TO A PATIENT, AND REPEATED NEGLIGENCE BECAUSE THOSE LEGAL CONCLUSIONS ARE UNAUTHORIZED BY LAW; ARE ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVE AN ABUSE OF DISCRETION; AND ARE UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE WHOLE RECORD: (A) IN THAT THE BOARD FAILED TO CARRY ITS BURDEN OF ESTABLISHING A STANDARD OF CARE FOR PHYSICIANS NOT HAVING AVAILABLE TO THEM A MEDICALLY APPROPRIATE REFERRAL ALTERNATIVE; (B) IN THAT THE COMMISSION'S LEGAL CONCLUSION THAT DR. TENDAI IS SUBJECT TO DISCIPLINE FOR NOT REFERRING MISS GRINDLE TO A PERINATOLOGIST IS ERRONEOUS IN LIGHT OF THE COMMISSION'S FINDING OF FACT THAT DR. TENDAI DID NOT REFER MISS GRINDLE TO THE ONLY AVAILABLE PERINATOLOGIST WHO WOULD ACCEPT MEDICAID PATIENTS DUE TO DR. TENDAI'S CONCERN THAT THE PERINATOLOGIST WOULD DELIVER THE BABY BEFORE ITS LUNGS WERE SUFFICIENTLY MATURE TO SURVIVE; (C) IN THAT REPEATED NEGLIGENCE CANNOT, UNDER MISSOURI LAW, RESULT FROM A PHYSICIAN'S CONTINUOUS COURSE OF TREATMENT CONCERNING A SINGLE PATIENT; (D) IN THAT THE COMPLAINT BEFORE THE COMMISSION DID

NOT ALLEGE THAT DR. TENDAI'S CONDUCT CONCERNING ONLY MISS GRINDLE CONSTITUTED REPEATED NEGLIGENCE; AND, (E) IN THAT THE COMMISSION FAILED TO CONSIDER EVIDENCE PROPERLY ADMITTED AND ERRONEOUSLY CONCLUDED THAT DR. TENDAI DID NOT REFER MISS GRINDLE TO A PERINATOLOGIST.

The Board mischaracterizes Dr. Tendai's argument, claiming that Dr. Tendai's basic argument "is that the Administrative Hearing Commission incorrectly accepted the Board's evidence as credible, as against his own . . . testimony." Board Brief at 20. Nothing could be further from the truth. Point II of Dr. Tendai's argument points out five different errors. Only one of those five errors, presented under Point II (E), attacks the Commission's acceptance of Miss Grindle's testimony over that of Dr. Tendai. All of the other portions of Point II of Dr. Tendai's argument accept, *arguendo*, the Commission's acceptance of Miss Grindle's testimony over Dr. Tendai's testimony. Consequently, none of the first four arguments under Point II of Dr. Tendai's Brief require this Court to consider the Commission's erroneous factual findings. Rather, they are focused purely on the Commission's erroneous legal conclusions, which this Court reviews *de novo*. *Concord Pub. House, Inc. v. Director of Revenue*, 916 S.W.2d 186, 189 (Mo. banc 1996).

(A) THE BOARD FAILED TO CARRY ITS BURDEN OF ESTABLISHING A STANDARD OF CARE FOR PHYSICIANS NOT HAVING AVAILABLE TO THEM A MEDICALLY APPROPRIATE REFERRAL ALTERNATIVE.

(B) THE COMMISSION'S LEGAL CONCLUSION THAT DR. TENDAI IS SUBJECT TO DISCIPLINE FOR NOT REFERRING MISS GRINDLE TO A PERINATOLOGIST IS ERRONEOUS IN LIGHT OF THE COMMISSION'S FINDING OF FACT THAT DR. TENDAI DID NOT REFER MISS GRINDLE TO THE ONLY AVAILABLE PERINATOLOGIST WHO WOULD ACCEPT MEDICAID PATIENTS DUE TO DR. TENDAI'S CONCERN THAT THE PERINATOLOGIST WOULD DELIVER THE BABY BEFORE ITS LUNGS WERE SUFFICIENTLY MATURE TO SURVIVE.

The Board cites no facts and no cases to defend the Commission's flawed decision in response to this portion of Dr. Tendai's argument. The Board cannot escape the fact that it bears the burden of proving the standard of care and Dr. Tendai's violation of the standard of care. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo.App.W.D. 1992); *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo.App.W.D. 1989). Quite simply, there was no expert testimony concerning the appropriate standard of care under the circumstances in this case because the testimony which the Commission adopted to support its finding that Dr. Tendai did not refer Miss Grindle to a perinatologist because Dr. Tendai was concerned that the only available perinatologist would attempt to deliver the baby before its lungs were sufficiently mature to survive was not presented until rebuttal. That is when the Board's witness, who had observed the entire trial, offered his testimony. L.F. 00502-511. Dr. Tendai's expert witness, Dr. Griffin, who had already testified and been excused, was not asked

to opine as to the standard of care under those circumstances. The Board's expert, Dr. Cameron, had given his opinion in a deposition taken one year before the hearing, and his testimony contained no opinion concerning a standard of care under those circumstances. Consequently, the Board failed to meet its burden of proof.

Had the Board not sandbagged Dr. Tendai and waited until rebuttal to tender the testimony of its investigator Brian Hutchings, then Dr. Tendai's expert witness could have offered an expert opinion concerning the standard of care under those circumstances. Further, the Board could have asked its expert witness a hypothetical question during his deposition, or asked him to testify at the hearing. However, the Board did neither. Inasmuch as the Board did not tender any evidence to support the Commission's critical finding as to the circumstances confronting Dr. Tendai until rebuttal, the Board is hardly in a position to complain that it "ought not . . . be required to present expert testimony negating every excuse Dr. Tendai is able to come up with to justify his failure to do the required testing or to make a referral to a physician who would." Board Brief at 35. The Board waited until rebuttal to offer the testimony which the Commission accepted as the controlling circumstances in this case. The Board bears the burden of proof and the Board failed to establish the standard of care (let alone a violation of the standard of care) based on the circumstances that the Commission found to exist. Consequently, the Commission Decision, and the Disciplinary Order of the Board which is premised upon the Commission Decision, should be reversed.

(C) REPEATED NEGLIGENCE CANNOT, UNDER MISSOURI LAW, RESULT

FROM A PHYSICIAN'S CONTINUOUS COURSE OF TREATMENT CONCERNING A SINGLE PATIENT.

The Board cited to *Dorman v. State Bd. Of Registration for the Healing Arts***,** No. W.D. 58840, 2001 Mo. App. Lexis 1741 (Mo. App. W.D. Oct. 9, 2001), to support the Commission's misguided conclusion that Dr. Tendai is subject to discipline for repeated negligence based upon his continuous course of treatment of Miss Grindle on November 9, November 16 and November 23, 1992.[2] *Dorman* does affirm the Commission's finding of repeated negligence. However, the court did not address the issue presented to this Court - that

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[2] The Board apparently mistakenly included a reference to negligence on November 2, 1992, at page 35 of the Board's Brief. The Commission specifically found that Dr. Tendai suspected IUGR on November 2, 1992, and sent Miss Grindle to Cox Hospital for a follow up ultrasound examination on that date to confirm that finding. There was no testimony before or finding by the Commission that Dr. Tendai's treatment of Miss Grindle through November 2, 1992, deviated from the standard of care.

repeated negligence may not lie against a physician for the same omission concerning one obstetric patient during a continuous course of treatment. To the contrary, the Commission found nine different shortcomings by Dr. Dorman to support its conclusion that Dr. Dorman was repeatedly negligent. Specifically:

> "the Commission found that Dr. Dorman's license was subject to discipline because he (1) failed diagnose an unstable angina or myocardial infarction on or before December 29, 1988; (2) failed to successfully refer E.F.S. to another doctor and continued to treat E.F.S. despite the fact that Dr. Dorman lacked the competence to do so; (3) injected E.F.S. with intravenous hydrogen peroxide; (4) failed to advise E.F.S. of the seriousness of his condition despite his history and symptoms; (5) caused E.F.S. pain in the period leading to his death because Dr. Dorman failed to diagnose E.F.S.'s cardiac condition, failed to inform E.F.S.'s family of his condition, and failed to refer E.F.S. to another doctor; (6) prescribed Theo-Dur, a drug that is contraindicated in cases of acute myocardial infarction; (7) failed to order a chest x-ray of E.F.S. on December 21, 1988, in light of E.F.S.'s symptoms on that date; (8) held himself out as competent to read an EKG; [and,] (9) failed to correctly read the x-rays Dr. Bateman had taken;. . ."

Dorman, at *15-16. Consequently, *Dorman* does not support discipline against Dr. Tendai for repeated negligence in his continuous course of care of one obstetric patient during three visits over a fifteen-day period.

Although not cited by the Board under this point of its argument, the Court of Appeals also considered repeated negligence in *Bever*. Therein, Dr. Bever claimed the Commission's decision was erroneous because there was insufficient expert testimony to support any finding of negligence. *Bever*, at *21. However, inasmuch as the court found that Dr. Bever was negligent in his treatment of two patients, it concluded that Dr. Bever was subject to discipline for repeated negligence. *Id*. Once again, however, the court was not presented with the challenge which Dr. Tendai presents to this Court, that a physician may not, as a matter of law, be subjected to discipline for repeated negligence in his care of one obstetric patient during one continuous course of treatment.

(D) THE COMPLAINT BEFORE THE COMMISSION DID NOT ALLEGE THAT DR. TENDAI'S CONDUCT CONCERNING ONLY MISS GRINDLE CONSTITUTED REPEATED NEGLIGENCE.

With the exception of one paragraph, the Board ignores this portion of Dr. Tendai's Brief. The Board's claim that it "adequately pleaded that Dr. Tendai was guilty of 'repeated negligence' in his treatment of Patient S.G." is completely unsubstantiated. Board Brief at 36. Count III of the pleading speaks for itself, and it does not allege that Dr. Tendai's treatment of Miss Grindle constituted repeated negligence. L.F. 00018-19. Consequently, the Commission granted relief not requested by the pleadings, exceeding its authority and abusing its discretion. *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo.App.E.D. 1984) *Duncan v. Bd. for Architects, Professional Eng'rs. and Land Surveyors*, 744 S.W.2d 524, 538-39 (Mo. App.

E.D. 1988). Therefore, the Commission's conclusion that Dr. Tendai was subject to discipline for repeated negligence must be reversed.

(E) THE COMMISSION FAILED TO CONSIDER EVIDENCE PROPERLY ADMITTED AND ERRONEOUSLY CONCLUDED THAT DR. TENDAI DID NOT REFER MISS GRINDLE TO A PERINATOLOGIST.

This is the only portion of Dr. Tendai's Brief wherein this Court is asked to find that the Commission's findings of fact, as opposed to its flawed conclusions of law, are erroneous.

The Board contends that Miss Grindle offered consistent credible evidence. That is not the case. Miss Grindle went shopping for an attorney to sue Dr. Tendai in January, following the November 29 stillborn birth of her child. L.F. 00629. Her testimony, given by deposition on April 2, 1998, approximately ten months before the Commission's hearing, has numerous inconsistencies and misrepresentations. For example, during direct examination, Miss Grindle stated that Dr. Tendai never told her that there was any problem with her pregnancy. L.F. 00581, Lines 20-25. On the very next page of the transcript, Miss Grindle again stated that Dr. Tendai never suggested to her that there was a problem with her fetus. L.F. 00582, Lines 19-21. Thereafter, Miss Grindle again stated that Dr. Tendai never mentioned that her baby was small. L.F. 00581, Lines 12-13.

Miss Grindle contradicted her direct testimony with the following admissions during cross-examination:

1. Miss Grindle admitted that Dr. Tendai told her, during the October 16, 1992

visit, that her baby was small. L.F. 00640, Line 19.

2. Miss Grindle admitted that Dr. Tendai stated during her office visit on November 2, 1992, that her baby hadn't grown since last month. L.F. 00645-646.

3. Miss Grindle also admitted that Dr. Tendai referred her to Cox Hospital for another ultrasound examination on November 2, 1992. L.F. 00643-645.

4. Miss Grindle further admitted that she suspected something was wrong because Dr. Tendai was concerned on November 2, 1992. L.F. 00646-648.

5. Miss Grindle also admitted that the ultrasound technician at Cox advised her on November 2, 1992, that her baby only weighed approximately three pounds and it would be up to Dr. Tendai as to whether he would keep her under his care or whether he would refer her to a specialist. L.F. 00647.

7. Miss Grindle further admitted that Donna Kennedy (Dr. Tendai's nurse) told her, during the November 9, 1992 visit, that the results of the Cox ultrasound concluded that she did have IUGR and that Dr. Tendai would explain the situation to her more completely during his examination. L.F. 00649.

The Commission ignored these important inconsistencies in Miss Grindle's testimony.

Miss Grindle's testimony concerning the frequency of her visits to Dr. Tendai's office was also false. Miss Grindle stated that Dr. Tendai saw her monthly only, until later in the pregnancy, when he saw her every two weeks. L.F. 00585. She then testified that he never suggested that she should be monitored more frequently than once every two weeks and that he never told her to come in more frequently than every two weeks. L.F. 00586, Lines 1-7.

Dr. Tendai's records clearly reflect, however, that he saw her weekly, from November 2, 1992, through November 23, 1992. L.F. 00802. While the Commission found that Dr. Tendai saw Miss Grindle on November 2, November 9, November 16 and November 23, it neglected to notice Miss Grindle's false testimony wherein she claimed that Dr. Tendai never asked her to come in more often than every two weeks.

Miss Grindle's recollection of the activities that occurred during her visits on November 16, 1992, and November 23, 1992, was also suspect. For example, Miss Grindle testified that Dr. Tendai never told her anything about her baby during her last two visits on November 16, 1992, and November 23, 1992. L.F. 00658-660. However, during cross-examination, Miss Grindle revealed her true recollection of these visits. When asked if she recalled the November 16, 1992 visit, she stated: "I don't remember." L.F. 00651, Lines 4-7. Then, when asked if she recalled the November 23 visit, she stated: "I mean I don't remember. I am sure I went." (L.F. 00653, Line 4).

In spite of those inconsistencies and misrepresentations, the Commission decided that Miss Grindle's testimony was more credible than that of Dr. Tendai. In large part, the Commission justified its decision on the rebuttal testimony of the Board's investigator, Brian Hutchings. Mr. Hutchings interviewed Dr. Tendai on April 6, 1993 L.F. 00503. Although he claimed that he took some questions with him to the interview and wrote Dr. Tendai's answers down during the interview, he never produced those documents in discovery and he did not offer any written materials in evidence to support those claims. L.F. 00509. Rather, Mr. Hutchings testified from his memory concerning a conversation that he had with Dr. Tendai

nearly six years before the hearing. L.F. 00505-507. Mr. Hutchings believed that Dr. Tendai told him he diagnosed the patient with IUGR, but told her that it was best if she carried the baby to term because he was concerned about the lung maturity of the baby and he did not want to refer her to perinatologist because the perinatologist would probably try to deliver the baby too early. L.F. 00505-507.

Mr. Hutchings received a copy of Dr. Tendai's records, which had been copied by his office manager, Paula Moore. L.F. 00127-128, 00505-506. Ms. Moore testified that she did not copy the sticky notes when she copied the file. L.F. 00128. Dr. Tendai had not even reviewed the file before he sat down for Mr. Hutchings' interview. L.F. 00331-332.

Although the Board made no inquiry of Mr. Hutchings concerning the second interview that he had with Dr. Tendai, Mr. Hutchings admitted during cross-examination that Dr. Tendai called him to arrange a second meeting when Dr. Tendai learned that the sticky notes had not been copied and delivered to Mr. Hutchings. L.F. 00504-505. Mr. Hutchings stated that Dr. Tendai told him that the sticky notes had not been copied for the Board and asked his advice as to whether it would be appropriate to take those notes with him when he was interviewed by the Board. L.F. 00509-511. Apparently, Mr. Hutchings made no report of that meeting to the Board of Healing Arts. In fact, Mr. Hutchings admitted that he had completely forgotten about the second meeting until Dr. Tendai discussed the same during his testimony on the previous day. L.F. 00509-510.

The Commission took that testimony and concluded that Dr. Tendai must have conjured up the sticky notes after the fact. This conclusion was partially based upon the Commission's

belief that Dr. Tendai did not know about a two-vessel cord until the November 2, 1992 ultrasound from Cox Hospital, which was noted on his sticky note of October 16, 1992. Dr. Tendai explained the discrepancy between the sticky note and the flow sheet for October 16, 1992, indicating that his nurse inaccurately indicated on the flow sheet a three-vessel cord, while the notes, which Dr. Tendai wrote, accurately reflected a questionable two-vessel cord. L.F. 00349 and 00802. The Commission ignored Dr. Tendai's testimony and seized upon this bit of evidence to support its finding that the sticky notes appeared to have been made after the fact. If Dr. Tendai intended to make notes after the fact to substantiate his actions, then surely they would have been much more complete and thorough than the cryptic contemporaneous notes which he made following Miss Grindle's visits. L.F. 00799-800.

The Board groundlessly claims that the Commission took the expert testimony of Dr. James Johnson for what it was worth. Board Brief at 43 and 44. That contention is completely unsubstantiated, inasmuch as the Commission Decision failed to mention Dr. Johnson's testimony. The Board also claims that Dr. Johnson simply accepted Dr. Tendai's statements as to what happened to Miss Grindle at face value, and that Dr. Johnson was unaware of Miss Grindle's versions of the events. Board Brief at 43. Obviously, the converse is also true for the Board's expert, Dr. Cameron, whose testimony was taken one year before the hearing and which did not consider Dr. Tendai's version of the events. L.F. 00514, 00563.

Not surprisingly, the Board does not address the critical directive of *Mineweld, Inc. v. Board of Boiler and Pressure Vessel Rules*, 868 S.W.2d 232, 234 (Mo.App., W.D. 1994), which establishes that a trier of fact may not ignore or arbitrarily disregard evidence without

explanation. That is precisely what the Commission did with the expert testimony of Dr. Johnson. The Commission's failure to consider this evidence is an abuse of discretion, arbitrary, capricious and unreasonable. Therefore, the Commission Decision must be reversed. *Psychare Management, Inc. v. Department of Social Services*, 980 S.W.2d 311, 312 (Mo. banc 1998).

POINT III

III. THE BOARD OF HEALING ARTS ("BOARD") ERRED IN ITS DECISION TO IMPOSE DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE BECAUSE SUCH ORDER VIOLATES DR. TENDAI'S RIGHTS TO EQUAL PROTECTION AND BECAUSE SECTIONS 334.100.2(5) AND 334.100.2(25) ARE UNCONSTITUTIONAL UNDER THE EQUAL PROTECTION CLAUSE, IN THAT THE BOARD'S DISCIPLINE WAS NOT RATIONALLY RELATED TO ITS OBJECTIVE OF PROTECTING THE PUBLIC, IN THAT DR. TENDAI RECEIVED DISCIPLINE FAR MORE SEVERE THAN OTHER PHYSICIANS ENGAGING IN SIMILAR OR MORE SERIOUS CONDUCT, AND IN THAT SECTIONS 334.100.2(5) AND 334.100.2(25) CREATE DIFFERING CLASSIFICATION OF PHYSICIANS SUSPECTED OF INCOMPETENCE AND ESTABLISH DIFFERENT PROCEDURAL RIGHTS BASED ON THIS CLASSIFICATION.

The Board's argument under this Point III essentially boils down to the following: since the Commission implied that Dr. Tendai created phony evidence, he necessarily lied under oath, which allows the Board of Healing Arts to impose any discipline it selects. Board Brief at 47. Furthermore, since Dr. Tendai had voluntarily limited his practice to gynecology, the Board's order permanently prohibiting him from practicing obstetrics did not harm him. Board's Brief at 46.

The Board's claim that Dr. Tendai was not damaged by a disciplinary order which finds him, among other things, incompetent and grossly negligent, and bars him from ever practicing

obstetrics again in the future, is absolutely ludicrous. Apparently, the Board does not believe that a physician is damaged by having his reputation ruined and having this disciplinary action published in the Board's quarterly report and placed in the National Practitioner's Data Bank. Obviously, Dr. Tendai was harmed by the Board's discipline.

The Board claims that it was justified in imposing any discipline it selected due to the presence of mendacity. However, the Board continues to demonstrate that it took that factor into consideration. Certainly, there is no such finding in its Disciplinary Order. As illustrated in the statement of facts in Dr. Tendai's Initial Brief, at pages 38-40, there are no findings whatsoever in the Disciplinary Order to explain why the Board imposed the chosen discipline. If the Board believed that Dr. Tendai falsified records, then why didn't the Board plead that violation of the Healing Arts Practice Act and seek findings and conclusions from the Commission on that violation? Furthermore, if the Board believed that Dr. Tendai falsified records, then why would it order Dr. Tendai to attend a course on medical records wherein physicians are instructed to keep more detailed records and practice defensive medicine. Finally, if the Board truly believed that Dr. Tendai was lying to protect himself and had simply let this patient's child die, then why didn't it revoke his license? We do not know, because the Board made no finding to justify its discipline.

What we do know, as shown by the eighty cases submitted by Dr. Tendai at the hearing before the Board, is that the Board has only reprimanded or imposed no discipline upon other physicians under extremely similar circumstances. Not surprisingly, the Board elected not to discuss in its Brief, just as it failed to discuss in its Disciplinary Order, any of the other

disciplinary cases which Dr. Tendai offered into evidence before the Board. The Circuit Court found that the Board's failure to make findings of fact as to the similarity or dissimilarity of Dr. Tendai's case with the prior cases presented to the Board by Dr. Tendai, constituted an error to the substantial prejudice of Dr. Tendai. L.F. 01986. The Board offered no authority to support its actions.

Dr. Tendai illustrated some of these cases in his Statement of Facts, at pages 35-36 of his initial brief. In response, the Board boldly asserts, without citing one case, that the cases offered into evidence by Dr. Tendai did not deal with situations as serious as his and did not involve situations where false statements were made. To illustrate the fallacy of the Board's unsubstantiated assertion, Dr. Tendai is compelled to summarize some of the cases which he offered into evidence before the Board, but were ignored by the Board.

The Board only reprimanded the license of James Stricklin, M.D., due to Dr. Stricklin's performance of an unnecessary operative procedure and writing an inaccurate history and physical to justify the surgery. L.F. 01352-54. The Board also only reprimanded the license of Ian A. Kling, M.D., after the Commission found cause to discipline Dr. Kling's license due to his knowingly giving a false answer on his application to obtain privileges at Barnes St. Peters Hospital, L.F. 01391-1400, even after the Commission made a specific finding that Kling's testimony was "inconsistent and evasive." L.F. 01398. The license of David S. Sneid, M.D., was reprimanded for giving inaccurate and untrue information in connection with his application for staff privileges at St. Joseph Health Center, by failing to disclose that his Missouri medical license had been limited when, in fact, he had voluntarily surrendered his

Missouri license and had it placed on probation. L.F. 01440-1448. The Board also reprimanded the license of Manuel C. Hugo, M.D., based upon discipline by the New Jersey Board of Medical Examiners based upon Dr. Hugo's failure to notify the parents of an infant patient of an abnormal test result relating to PKU testing; based upon a consent agreement which he entered into with the Maine Board of Registration and Medicine due to his failure to report his New Jersey discipline on his Maine licensure renewal applications on three separate occasions; and, due to his false statement on his Missouri application wherein he stated that he had not had his license disciplined by any other state. L.F. 01449-1459.

The Board reprimanded the license of Debra K. Duello, M.D., based upon Dr. Duello's admissions that she engaged in conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public, incompetency, gross negligence or repeated negligence in the performance of the function or duties of her profession, due to her failure to diagnose a patient's pregnancy, in spite of numerous examinations between April 1, 1993, and August 12, 1993, at which time she performed a hysterectomy on the patient which was contraindicated and fell below the acceptable medical standards of practice, resulting in the demise of the fetus. L.F. 01525-1530.

The Board also reprimanded the license of Allen S. Wasserman, M.D., based upon discipline by the Texas State Board of Medical Examiners which was premised upon Dr. Wasserman's poor judgment in transporting an unstable OB patient and use of an improper instrument in a circumcision. Furthermore, the doctors privileges at a hospital were revoked for leaving the operating room for thirty-five minutes with the patient anesthetized and

intubated in spine lithotomy position with laproscopic trocar sheaths remaining in the abdomen. L.F. 01590-1598.

The license of Frank Cho, M.D., was reprimanded, L.F. 01784-1786, after the Commission found that Dr. Cho had been found guilty of sexual battery; and, that Dr. Cho knowingly used false statements on his Kansas and Missouri applications in an effort to fraudulently obtain a license. L.F. 01787-1799.

The Board reprimanded the license of Arthur N. Lee, Jr., M.D., over the death of his patient following the doctor's admission that his conduct fell below the accepted standards of care by failing to perform certain tests on the patient, failing to return calls of another physician concerning the patient's health, failing to consult with another physician concerning the patient's health, and failing to forward the patient's medical records to another physician. L.F. 01800-1807.

The Board also reprimanded the license of Michael E. Blank, M.D., based upon his violation of the drug laws or rules of Missouri and conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient resulting from his care and treatment of five different patients wherein he overprescribed controlled substances and failed to adequately document data concerning these prescriptions, examinations and diagnoses. L.F. 01818-1829.

The Board elected not to discipline the license of Dalrie Berg, D.O., even though the Colorado Board of State Medical Examiners placed Dr. Berg's license on probation for five years and ordered Dr. Berg not to engage in the practice of obstetrics based upon two or more

acts or omissions by Dr. Berg which failed to meet the generally accepted standards of medical practice. L.F. 01855-1857. The Board also elected to impose no discipline against the license of Marcellus Lawrence, M.D., even though the Commission found cause to discipline his license, based upon his conviction of an offense involving moral turpitude wherein he pleaded guilty to driving under the influence three times within a three year period, and based upon Dr. Lawrence's misrepresentation to the Board that he had not been arrested or pleaded guilty to DUI charges. L.F. 01858-1874.

The Board elected to impose no discipline against Valentino Andres, Jr., M.D., even after the Commission found cause to discipline his license based upon his plea of "no contest" in California to charges of sexual exploitation of a patient by a psychotherapist and the imposition of discipline upon his license by the state of California, including seven years of probation. L.F. 01875-1881.

The Board also elected to impose no discipline against the license of Frank Campobasso, D.O., even though the Commission found cause to discipline his license based upon restrictions imposed upon his controlled substance authority by the Missouri Bureau of Narcotics and Dangerous Drugs ("BNDD") and based upon his violation of a Memorandum of Understanding which he entered into with BNDD. L.F. 01882-1914.

Finally, the Board elected to impose no discipline against the license of Rex T. Martin, D.O., even though the Commission found cause to discipline his license based upon disciplinary action by the Maine Board of Osteopathic Licensure due to his violation of his consent agreement with the Maine Board. The consent agreement in Maine was based upon

dispensing controlled substances in unlabeled envelopes; prescribing large quantities of controlled substances to a number of patients and continuing to prescribe scheduled drugs to some patients without adequate medical justification in his records; treatment of patients with controlled substances without attempting other treatment modalities, ordering lab tests or obtaining consultations; and, failing to obtain complete medical histories and make detailed physical findings in his progress notes. Under the Maine Consent Agreement, Dr. Martin was not to prescribe controlled substances without following certain conditions. Dr. Martin violated those conditions. Nonetheless, the Missouri Board elected to impose no discipline. L.F. 01915-1919.

As these cases illustrate, contrary to the Board's assertions, the Board has had numerous other cases where physicians have been found to have been incompetent and grossly negligent, and have been found to have engaged in conduct harmful or dangerous to a patient and repeatedly negligent, and have only been reprimanded by the Board. Furthermore, in some of these cases, physicians were specifically found to have been less than candid with the Board or the Commission. However, the Board chose, in those cases, only to reprimand or impose no discipline. Why did the Board impose more sever discipline upon Dr. Tendai? Probably to satisfy the Board's counsel's demand for punishment. In closing argument, the Board's counsel demanded punishment and the Board gave it to him. L.F. 01177. Based upon the evidence before the Board, punishment was not justified. Imposing disparate punishment denied Dr. Tendai due process and equal protection under the law. Consequently, Dr. Tendai's punishment should be reversed.

CONCLUSION

For any or all of the above-stated reasons, the Commission Decision and the Board's Disciplinary Order should be reversed and set aside because they are: (1) in violation of Constitutional provisions; (2) unsupported by competent and substantial evidence upon the whole record; (3) unauthorized by law; (4) made upon unlawful procedure and without a fair trial; (5) arbitrary, capricious and unreasonable; and, (6) involve an abuse of discretion.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that two true and correct copies of the above and foregoing document and one copy of the disk required under Special Rule No. 1(f) were served this 7th day of January, 2002, by either U.S. Mail, postage prepaid, or hand-delivery to the following: Mr. Glenn Bradford, 1150 Grand Avenue, Suite 230, Kansas City, Missouri 64104; and Mr. Duane E. Schreimann, 221 Bolivar Street, Jefferson City, MO 65102.

CERTIFICATE OF COMPLIANCE

Pursuant to Missouri Supreme Court Special Rule No. 1, Respondent hereby certifies that this brief complies with the limitations contained in Special Rule No. 1(b) and that, according to the word count feature in WordPerfect, the entire brief, excluding the cover, contains 7,711 words. Respondent further certifies that, pursuant to Special Rule No. 1(f), it is filing with this brief a computer disk which contains a copy of the above and foregoing brief, which was prepared using WordPerfect 8.0, and Respondent also certifies that the disk has been scanned for viruses and is virus-free.

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