**NO. SC86110**

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**IN THE SUPREME COURT OF MISSOURI**

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**Mark M. Tendai, M.D.,**

**Appellant,**

**v.**

**Missouri State Board of Registration for the Healing Arts,**

**Respondent.**

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**APPEAL FROM THE CIRCUIT COURT OF COLE COUNTY,**
**NINETEENTH JUDICIAL DISTRICT, DIVISION I**
**THE HONORABLE THOMAS J. BROWN, III**
**Case No. 00CV323854**

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# BRIEF OF RESPONDENT

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## RESPONDENT'S STATEMENT OF FACTS

Petitioner[1] Dr. Mark M. Tendai (hereafter Dr. Tendai), a licensee of the Missouri State Board of Registration for the Healing Arts (hereafter the Board of Healing Arts or the Board), filed his Petition for Judicial Review Pursuant to Section 536.100 and for Stay Order Pursuant to Section 536.120 (hereafter referred to as "Petition for Judicial Review") in the Circuit Court of Cole County, Missouri, and sought to have the Court overturn discipline against his medical license imposed by the Board of Healing Arts in its Findings of Fact, Conclusions of Law and Order dated May 15, 2000 (hereafter referred to as "Board Disciplinary Order."). (L.F. 01940) The Board Disciplinary Order, in turn, was based on Findings of Fact and Conclusions of Law issued by the Missouri Administrative Hearing Commission on September 2, 1999, wherein the Commission found cause for discipline against Dr. Tendai's license based on violations of Section 334.100.2(5), RSMO, related to his treatment of patient S.G. (hereafter referred to as "Commission Findings.")(L.F. 01935).

Dr. Tendai, practicing as an obstetrician/gynecologist in Springfield, Missouri, saw a pregnant patient S.G. for the first time on April 14, 1992. (Petitioner's Exhibit 3,

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[1] Dr. Tendai is the petitioner in this case. However, Dr. Tendai was the respondent before the Administrative Hearing Commission and the Board of Healing Arts. To avoid confusion, the Board will refer to petitioner as "Dr. Tendai" and respondent as "the Board." Exhibits from the administrative process are referred to as they were marked. For the purpose of identifying exhibits, Dr. Tendai is "respondent" and the Board is "petitioner."

Respondent's office medical records for patient S.G.)(L.F. 1356-57). Dr. Tendai estimated the gestational age of patient S.G.'s fetus as seven weeks. (Id.) Monthly visits continued through September 21, 1992. (Id.) During this time frame, the only abnormality, complication, or problem noted by Dr. Tendai was that patient S.G. tested positive for chlamydia. (Id.) Patient S.G. was treated for this condition. (Id.) Following the September 21, 1992, monthly visit, patient S.G saw Dr. Tendai every other week. (Id.)

On October 16, 1992, after an in-office ultrasound, Dr. Tendai suspected the fetus had a condition known as intrauterine growth retardation (IUGR). (Id.) IUGR is a potentially life-threatening problem for the fetus but the treatment for IUGR is well-established and adequate treatment and management normally addresses the problem in most cases. (Petitioner's Exhibit 1, Deposition of Dr. William Cameron, page 9, line 19 to page 10, line 20)(L.F. 784-85). At that time, on October 16, 1992, patient S.G. was instructed by Dr. Tendai to have an ultrasound performed at Cox South Hospital in Springfield, Missouri. Patient S.G. complied with Dr. Tendai's recommendation and the ultrasound was performed on November 2, 1992. (Petitioner's Exhibit 3, Report of Radiological Consultation, dated January 25, 1993)(L.F. 1361). The radiologist's opinion was that the fetus had IUGR and the radiologist also noted that a two-vessel umbilical cord was present instead of the normal three-vessel cord. (Id.)

After receiving the results of the Cox ultrasound, Dr. Tendai diagnosed a condition of IUGR. (Testimony of Dr. Tendai, Trial Transcript, page 231, line 15 to line 25)(L.F. 521). According to patient S.G., Dr. Tendai never so much as mentioned IUGR and patient S.G. unequivocally testified that Dr. Tendai did not refer her to a perinatologist or any other

specialist. (Petitioner's Exhibit 2, Deposition of patient S.G., April 2, 1998, page 16, line 1 to page 17, line 2)(L.F. 851). Dr. Tendai did not recommend more frequent monitoring. (Id.) Dr. Tendai did not recommend amniocentesis. (Id. at page 69, lines 17 to 19)(L.F. 903). Dr. Tendai did not indicate to patient S.G. that there was a problem with her baby. (Id.) Patient S.G. just thought that she was going to have a small baby but she did not consider this to be a critical problem. (Id. at page 22, lines 2 to 12)(L.F. 857). Nobody told her that this could be a serious problem. (Id. at page 15, lines 20 to 25)(L.F. 850). According to patient S.G., at no time after this ultrasound did Dr. Tendai suggest to S.G. that a visit to a perinatologist would be wise under the circumstances. (Id. at page 22, lines 2 to 12)(L.F. 857).

On November 28, 1992, late in the evening, patient S.G. went to Cox South Hospital and complained that she had not felt any fetal movement for about twenty-four hours. (Petitioner's Exhibit 3, Respondent's office medical records for patient S.G.)(L.F. 1354-1454). No fetal heart tones were detected. (Id.) After an ultrasound, patient S.G. was transferred to the delivery room and delivered baby Mariah, a stillborn child. (Id.) Dr. Tendai was not present. (Id.) Twenty-six days elapsed after Dr. Tendai's formal diagnosis of IUGR and fetal demise on November 28, 1993. During this 26-day period, Dr. Tendai documented no steps to treat or manage patient S.G.'s condition of IUGR. (Id.)

The autopsy conducted revealed that "[i]ntrauterine fetal death was most likely due to the combined effects of a tight nuchal cord and severe chronic villitis of unknown etiology involving the placenta with associated intrauterine fetal growth retardation." (Petitioner's Exhibit 3; Necropsy Report, dated January 20, 1993)(L.F. 1370). The report went on to state

that "[u]mbilical artery thrombosis is a common finding in placental vessels of stillborns. Other findings included a two- vessel umbilical cord. Although the two-vessel cords are associated with an increased incidence of fetal congenital malformations, no other congenital malformations are identified." (Id.)

Dr. Tendai testified at trial in the AHC that he had repeatedly advised patient S.G. of the condition of IUGR, the dangers presented by IUGR, and that she should consult with a perinatologist. Dr. Tendai further testified that patient S.G. had ignored his advice. Patient S.G. denied that Dr. Tendai had advised her of the seriousness of IUGR or referred her to a perinatologist. In an interview with Board Investigator Bryan Hutchings conducted some four months after the demise of patient S.G.'s baby, Dr. Tendai indicated to Investigator Hutchings that he did not refer patient S.G. to the local perinatologist because, in his opinion, she tended to deliver IUGR babies too soon before their lungs were mature and that he felt that the best course of action for patient S.G. was to simply try to carry the baby to term. (L.F. 479) Dr. Tendai did not mention to Investigator Hutchings anything to the effect that patient S.G. had failed to follow his advice. (L.F. 481, lines 1 through 3).

After he had submitted the ongoing patient records for patient S.G. to the Board in response to a Board subpoena, Dr. Tendai contacted Investigator Hutchings and claimed that his office had just located two "sticky notes" related to the patient S.G. matter that had been misfiled and only recently discovered. (L.F. 483-84) Dr. Tendai presented the "sticky notes" to the Board and later to the AHC in the hearing on the Board's Complaint. The "sticky notes"

tended to confirm Dr. Tendai's claims that he advised patient S.G. to see a perinatologist but that she had refused.

The Administrative Hearing Commission found that Dr. Tendai had engaged in a course of conduct in his treatment of patient S.G. which was held to constitute incompetence, gross negligence and conduct harmful and dangerous to the health of the patient. (L.F. 1034) The Commission also found that, in his treatment of patient S.G., Dr. Tendai failed, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of Dr. Tendai's profession and that Dr. Tendai was thereby guilty of "repeated negligence" within the meaning of Section 334.100.2(5), RSMO. (L.F. 1034) The Commission thus found that Dr. Tendai's conduct as set out in Count I and Count III of the First Amended Complaint provided a basis for discipline by the Board under the provisions of Section 334.100.2(5). (L.F. 1034) Based on the Commission Findings, the Board Disciplinary Order was issued on May 15, 2000. (L.F. 01935)

Dr. Tendai appeared before the Board at his disciplinary hearing on April 28, 2000. (L.F. 01122) Dr. Tendai was represented by counsel and presented testimony and evidence in his own behalf. (L.F. 01122) Dr. Tendai testified before the Board that he no longer practiced in the area of obstetrics and had not done so for some three-and-one-half years. (L.F. 01155) Dr. Tendai testified that he had stopped doing obstetrics and focused on gynecology because he "got tired" and "that it was time I got to know my kids a little better and needed a little bit more of a life . . . " (L.F. 01155) Counsel described Dr. Tendai's elimination of his obstetrics practice as the result of a "long-standing plan." (L.F. 01189)

The disciplinary action imposed by Respondent Board, as set out in the Board Disciplinary Order included a public reprimand, together with a suspension of Dr. Tendai's medical license for a period of sixty (60) days. (L.F. 01935) The Board also ordered that, after Dr. Tendai's period of suspension, his license would be restricted in that Dr. Tendai would not be allowed to practice obstetrics or perform obstetrical procedures in the State of Missouri. Dr. Tendai was also ordered to attend a medical records seminar. The Board Disciplinary Order required that Dr. Tendai immediately return to the Board his wall-hanging certificate, license and pocket card, and all other indicia of licensure, to be held by the Board during the period of suspension.

Dr. Tendai sought relief from the Circuit Court of Cole County, which entered its Ex Parte Order Staying Enforcement of Disciplinary Order Pursuant to Section 536.120, RSMO, on May 15, 2000. (L.F. 01974) In his Petition for Judicial Review filed in Circuit Court, Dr. Tendai claimed that the orders of the Administrative Hearing Commission and the Board of Healing Arts, respectively, were not based on substantial and competent evidence. (L.F. 01940) Dr. Tendai further argued that Respondent Board of Healing Arts violated the Missouri Open Meetings Law by holding closed deliberations after the completion of Dr. Tendai's scheduled disciplinary hearing in front of the Board, which hearing was held in open session on April 28, 2000, after due notice to Dr. Tendai and the public. (L.F. 01940)

In accordance with Missouri law and Board custom and practice, the Board went into closed session upon completion of hearing the evidence in Dr. Tendai's disciplinary hearing. Dr. Tendai reasoned that the failure to conduct deliberations in open session is a violation of

the Open Meetings Law, thereby vitiating his license discipline as imposed by the Respondent Board, as set out in the Board's Disciplinary Order issued on May 15, 2000. The Circuit Court of Cole County, Hon. Thomas J. Brown, III, entered his Order and Judgment on Petition for Review Under Chapter 536.100, RSMo, on May 29, 2001. (L.F. 01983) The Circuit Court rejected all of Dr. Tendai's challenges to the Orders of the Administrative Hearing Commission and the Board of Registration for the Healing Arts, except that the Court remanded the case to the Board for the entry of findings of fact as to the similarity or dissimilarity of Dr. Tendai's case to the prior Board disciplinary cases cited by Dr. Tendai. (L.F. 01985-86)

Dr. Tendai appealed the Order & Judgment to this Court, which dismissed the appeal for lack of finality because the Board of Healing Arts had not yet issued an amended Disciplinary Order in abeyance of the remand for consideration of the Equal Protection issues raised by Dr. Tendai. *Tendai v. Missouri State Bd. of Reg'n. for the Healing Arts,* 77 S.W.3d 1, 2 (Mo. banc 2002). When the Circuit Court once again took jurisdiction of the case, the Board sought a writ of prohibition, arguing that the Circuit Court had no statutory jurisdiction to remand the case back to the Board of Healing Arts for findings on the Equal Protection issues. This Court ultimately decided the writ proceeding, resulting in this Court's December 9, 2003 decision in Case No. SC85285, which made absolute the writ sought by the Board and which directed the Circuit Court to make findings of fact on the equal protection issues. *See State Bd. of Reg'n. for the Healing Arts v. Brown*, 121 S.W.2d 234, 237-38 (Mo. banc 2003).

After oral arguments by the parties, the Circuit Court, based on the evidence already in the

record, entered its Findings of Fact, Conclusions of Law and Judgment on June 1, 2004, ("Judgment") (Appellant's Appendix 3) in which it made specific findings concerning Dr. Tendai's Equal Protection claims and affirmed the Decisions of the Commission and Board in their entirety. Dr. Tendai is thus appealing the combined Decisions of the Commission and the Board; and, the Judgment, pursuant to § 621.145, RSMo. 2000.

## ii. POINTS RELIED ON

**I. THE ADMINISTRATIVE HEARING COMMISSION DID NOT ERR IN ITS APPLICATION OF THE DISCIPLINARY TERMS "INCOMPETENCE," "REPEATED NEGLIGENCE," "CONDUCT DANGEROUS TO A PATIENT," AND "GROSS NEGLIGENCE" UNDER THE PROVISIONS OF SECTION 334.100.2(5), RSMo, IN THAT THE STATUTE IS NOT UNCONSTITUTIONALLY VAGUE AND, AS APPLIED, DID NOT VIOLATE DR. TENDAI'S DUE PROCESS RIGHTS.**

*State v. Young*, 695 S.W.2d 882, 883 (Mo. banc 1985)

*State of Missouri ex rel. Hurwitz v. North*, 271 U.S. 40, 46 S.Ct. 384, 385, 70 L.Ed. 818 (Mo . 1926)

*Artman v. State Bd. of Registration for Healing Arts*, 918 S.W.2d 247 (Mo. banc 1996)

**II. THE ADMINISTRATIVE HEARING COMMISSION DID NOT ERR IN FINDING THAT DR. TENDAI HAD VIOLATED SECTION 334.100.2(5), RSMo, IN THAT DR. TENDAI'S TREATMENT OF PATIENT S.G. VIOLATED THE APPLICABLE STANDARDS OF CARE.**

*State ex rel. Drury Displays, Inc. v. City of Olivette*, 976 S.W.2d 634, 635 (Mo. App. E.D. 1998).

*Bush v. Kansas City Public Service Co.*, 350 Mo. 876, 169 S.W.2d 331, 334 (Mo. 1943)

*State Bd. of Registration for the Healing Arts v. Levine*, 808 S.W.2d 440, 442 (Mo.App. W.D.1991).

**III. THE BOARD OF REGISTRATION FOR THE HEALING ARTS DID NOT ERR IN IMPOSING DISCIPLINE ON DR. TENDAI'S LICENSE AS A RESULT OF THE COMMISSION'S FINDINGS OF "INCOMPETENCY," "GROSS NEGLIGENCE," "REPEATED NEGLIGENCE," AND CONDUCT DANGEROUS TO THE HEALTH OF A PATIENT, WHICH FINDINGS AND CONCLUSIONS INCLUDED THE FINDING THAT DR. TENDAI PRESENTED FALSE EVIDENCE TO THE COMMISSION IN ORDER TO ESTABLISH A DEFENSE IN THE FORM OF THE "STICKY NOTES" WHICH THE COMMISSION FOUND TO HAVE BEEN MADE AND ADDED TO THE PATIENT FILE AFTER THE FACT.**

*In re Estate of Latimer*, 913 S.W.2d 51, 57 (Mo. App. W.D. 1995)

*Conway v. Mo. Com'n on Human Rights*, 7 S.W.3d 571, 575 (Mo. App. E.D. 1999)

*State Bd. of Registration for the Healing Arts v. Finch*, 514 S.W.2d 608, 616 (Mo.App.1974)

**IV. THE BOARD OF HEALING ARTS DID NOT ERR IN ITS ORDER IMPOSING DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE, IN THAT SAID ORDER WAS MADE UPON LAWFUL PROCEDURE, WAS AUTHORIZED BY LAW, WAS NOT ARBITRARY, CAPRICIOUS OR UNREASONABLE, DID NOT INVOLVE AN ABUSE OF DISCRETION, AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD.**

*Greenbrier Hills Country Club v. Director of Revenue*, 935 S.W.2d 36 (Mo. 1996)

*O'Flaherty v. State Tax Com'n of Missouri*, 680 S.W.2d 153 (Mo. 1984)

Section 620.010.14(8), RSMo Supp. 2003

Section 536.067, RSMo 2000

Section 621.110, RSMo 2000

## iii. ARGUMENT

**I. THE ADMINISTRATIVE HEARING COMMISSION DID NOT ERR IN ITS APPLICATION OF THE DISCIPLINARY TERMS "INCOMPETENCE," "REPEATED NEGLIGENCE," "CONDUCT DANGEROUS TO A PATIENT," AND "GROSS NEGLIGENCE" UNDER THE PROVISIONS OF SECTION 334.100.2(5), RSMo, IN THAT THE STATUTE IS NOT UNCONSTITUTIONALLY VAGUE AND, AS APPLIED, DID NOT VIOLATE DR. TENDAI'S DUE PROCESS RIGHTS.**

### Standard of Review

Judicial review of the orders of the Board of Healing Arts and the Administrative Hearing Commission is authorized under the provisions of Sections 621.145, RSMo,1994, as well as 536.100 through 536.150, RSMo,1994**.** The Board Disciplinary Order and the Commission Findings, may be reviewed and challenged if the agency action:

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

(F) erroneously announces and applies Missouri law; and therefore is reviewable by this Court under the provisions of Sections 621.145, RSMO,1994 , and Section 536.140, RSMo,1994.

The agency decision must be upheld if it is supported by substantial evidence upon the whole record. Section 536.140.2(3), RSMo 1994. The record must be viewed in the light most favorable to the agency decision. *State Bd. of Registration for the Healing Arts v. Finch*, 514 S.W.2d 608, 616 (Mo.App. 1974); *Mendelsohn v. State Bd. of Registration for the Healing Arts*, 3 S.W.3d 783, 786 (Mo. 1999). Upon review in a physician licensure proceeding, decisions of the Administrative Hearing Commission are presumed valid and the burden is on the attacking party to overcome the presumption. *Hernandez v. State Board of Registration for Healing Arts*, 936 S.W.2d 894, 900 (Mo.App. W.D.1997).

The Agency's findings of fact are given great deference as the fact finding process is a function of the agency and if evidence would warrant either of two opposed findings, the reviewing court must uphold the factual determinations the agency has made. *Fritzshall v. Bd. of Police Comm'rs*, 886 S.W.2d 20, 23 (Mo.App. W.D. 1994)(citing *Overland Outdoor Advertising Co., Inc. v. State Highway Comm'n*, 616 S.W.2d 563, 566 (Mo. App. W.D. 1981)).

**(A.) <u>Due Process Arguments</u>**

Dr. Tendai makes the claim that all or virtually all of the stated bases for discipline set out under the provisions of Section 334.100.2(5), RSMo, are void for vagueness and the

statute as applied to him thereby violates his right to procedural due process. Statutes are presumed to be constitutional and will be held to be unconstitutional only if they clearly contravene some constitutional provision. *State v. Young*, 695 S.W.2d 882, 883 (Mo. banc 1985). Doubts will be resolved in favor of constitutionality. *Id.*

It was held early on that this section of the Healing Arts Practice Act is not generally a denial of equal protection of the laws or due process. *State of Missouri ex rel. Hurwitz v. North*, 271 U.S. 40, 46 S.Ct. 384, 385, 70 L.Ed. 818 (Mo. 1926). It is not enough for a physician challenging the statute governing discipline to show that the statute might operate unconstitutionally in some cases. *Artman v. State Bd. of Registration for Healing Arts*, 918 S.W.2d 247 (Mo. banc 1996). Rather, the physician must show that, as applied to him, the Board used its power in an arbitrary or discriminatory manner. *Id.*

Due process requires that a statute prohibiting certain activity provide (1) reasonable notice of the proscribed activity and (2) guidelines so that the governmental entity responsible for enforcing the statute may do so in a nonarbitrary, nondiscriminatory fashion. *City of Festus v. Werner*, 656 S.W.2d 286, 287 (Mo.App.E.D. 1983). Upon a challenge to a statute as being unconstitutionally vague, the language is to be treated by applying it to the facts at hand. *State ex rel. Williams v. Marsh*, 626 S.W.2d 223, 233 (Mo. banc 1982).

The statute in question, Section 334.100.2(5), RSMo, is a disciplinary statute which has as its purpose the protection of the public, and as such, is remedial rather than penal. *Younge v. State Board of Registration for the Healing Arts*, 451 S.W.2d 346, 349 (Mo.1969), *cert. denied*, 397 U.S. 922, 90 S.Ct. 910, 25 L.Ed.2d 102 (1970). Remedial statutes are to be

construed to meet the cases which are clearly within the spirit or reason of the law, or within the evil the statute was designed to remedy, provided such interpretation is not inconsistent with the language used, with all reasonable doubts resolved in favor of applicability of the statute to the particular case. *State ex rel. LeFevre v. Stubbs*, 642 S.W.2d 103, 106 (Mo. banc 1982).

Dr. Tendai argues as if he were entitled to the due process rights due a criminal defendant. He seeks to subject the disciplinary provisions of the Healing Arts Practice Act to the intense scrutiny constitutionally reserved for penal criminal statutes. However, the cases have made clear that a licensee does not have the full panoply of rights guaranteed under the due process clause to a criminal defendant. The statute is remedial, which means in this context that strict due process standards are subordinated to the primary remedial nature of the statute for the purpose of protecting the public. *Perez v. Missouri State Bd. of Registration for the Healing Arts*, 803 S.W.2d 160, 165 (Mo. App. W.D. 1991). Statutory language which might be viewed as vague in a criminal statute might well be acceptable in a licensing discipline context.

This Court has recently held that courts employ "greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe." *Cocktail Fortune v. Sup'r of Liq. Control*, 994 S.W.2d 955, 957-58 (Mo. banc 1999); *State ex rel. Nixon v. Telco Directory Pub.*, 863 S.W.2d 596, 600 (Mo. banc 1993). Although the present case is not strictly speaking a civil case, it is certainly not a criminal case. However, even in criminal cases, neither absolute certainty nor impossible standards

of specificity are required in determining whether terms are impermissibly vague. *State v. Duggar*, 806 S.W.2d 407, 408 (Mo. banc 1991).

In *Perez v. Missouri State Bd. of Registration for the Healing Arts,* 803 S.W.2d 160, 165 (Mo. App. W.D. 1991), the Western District Court of Appeals held that the section prohibiting a physician from engaging in dishonorable, unethical, or unprofessional conduct or conduct of a character likely to deceive, defraud, or harm the public was not unconstitutionally vague as it was applied to a physician who engaged in sex with a patient while using his position of trust to gain her confidence. The Court held that "Dr. Perez clearly engaged in dishonorable, unethical and unprofessional conduct of a character likely to harm the public." 803 S.W.2d at 165. Section 334.100.1(10) was held by the Court of Appeals not to have been applied in an arbitrary or discriminatory fashion under the facts of that particular case.

In the present case the Commission held that Dr. Tendai failed to follow the applicable professional standards of care for treating IUGR (intrauterine growth retardation) and was therefore guilty of "gross negligence" and "incompetence." (Commission's Findings of Fact and Conclusions of Law, p. 22)(L.F. 294) "We conclude that Tendai violated the standard of care after November 2, 1992, by failing to refer the patient to a perinatologist or by failing to conduct tests and deliver the baby after its lungs reached maturity." (Commission's Findings of Fact and Conclusions of Law, p. 17-18)(L.F. 289-90) The Commission explained:

> There is no provision for discipline for ordinary negligence
>
> under section 334.100.2(5), only for repeated negligence and

gross negligence. We conclude that Tendai's omissions in the treatment of S.G. constitute a gross deviation from the standard of care and demonstrate a conscious indifference to a professional duty.

We further conclude that Tendai's conduct demonstrated a general lack of a disposition to use his professional ability; thus, there is cause to discipline his license for incompetence.

His conduct was also harmful to the health of a patient. Therefore, we conclude that there is cause to discipline Tendai's license under section section 334.100.2(5) for his treatment of S.G.

(Commission's Findings of Fact and Conclusions of Law, p. 18)(L.F. 290)

**(1) "<u>Incompetence" and "gross negligence</u>"**

Although the statute itself does not define "incompetence" or "gross negligence," the case law has developed definitions for these terms. "Incompetence" has been judicially defined as "a general lack of present ability or lack of a disposition to use a present ability to perform a given duty." *Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524 (Mo. App. E.D. 1988); *Forbes v. Missouri Real Estate Commission*, 798 S.W.2d 227 (Mo. App. W.D. 1990). "Gross negligence" has been judicially defined as "an act or course of conduct which demonstrates a conscious indifference to a professional duty"

that constitutes "a gross deviation from the standard of care which a reasonable person would exercise in the situation." *Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524, 533 and note 6 (Mo. App. E.D. 1988).

It is difficult for the Board to conceive of more complete and thorough definitions for these two statutory terms. "It is impossible to categorize all the acts constituting such as 'unprofessional conduct' or 'gross negligence.'" *Ray v. Dept. of Registration*, 94 Ill. App. 3d 1123, 50 Ill. Dec. 305, 419 N.E.2d 413 (1981)(quoted with approval in *Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524, 532 (Mo. App. E.D. 1988)).

In *Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524 (Mo. App. E.D. 1988), the Eastern District stated:

> While the parties are in disagreement as to the correct definition of "gross negligence" it is clear that the term connotes an improper conduct greater either in kind or in degree or both than ordinary negligence. It is to be presumed that any licensed professional knows that he is to perform his professional duties with the degree of care required under the particular circumstances involved, i.e., free from negligence. The statute

> serves to advise the professional engineer that improper conduct greater in kind or in degree than lack of ordinary care will subject him to disciplinary action. The phrase provides a guideline sufficient to preclude arbitrary and discriminatory application.

*Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524, 532 (Mo. App. E.D. 1988).

It must be presumed in the present case that Dr. Tendai knew that he was to abide by the standard of care, i.e., avoid negligence. As the *Duncan* court stated, the statute's inclusion of the term "gross negligence" as a basis for discipline serves to advise the [licensed physician] that improper conduct greater in kind or in degree than lack of ordinary care will subject him to disciplinary action.

Both the terms "incompetence" and "gross negligence" have been defined to turn on the basic act of being indifferent to the welfare of the patient (client). Here the Commission found that Dr. Tendai did not explain the condition of IUGR to S.G., did not refer her to a perinatologist and did not personally conduct any "failure to thrive" monitoring. In other words, he did absolutely nothing to try to preserve the life of baby Mariah. Presumably, Dr. Tendai had the knowledge and skill with which to treat patient S.G.'s condition of IUGR. However, he did nothing whatsoever to help her. This is conduct plainly showing a marked indifference to the welfare of patient S.G. In consideration of the facts of this specific case, the term "gross negligence" is not constitutionally vague. The Board would suggest that the

facts of this case easily qualify as both "incompetence" and "gross negligence."

"Incompetence" has been judicially defined as "a general lack of present ability or lack of a disposition to use a present ability to perform a given duty." *Missouri Bd. for Architects , Prof'l Engineers & Land Surveyors v. Duncan*, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n, November 15, 1985), aff'd, 744 S.W.2d 524 (Mo. App. E.D. 1988). It is clear that Dr. Tendai correctly diagnosed S.G.'s condition of IUGR and that he was aware of the danger and risks of IUGR and the proper course of treatment for IUGR. According to S.G., whose testimony was believed and accepted by the AHC, Dr. Tendai never advised her that he had diagnosed IUGR, that IUGR presented a danger to her unborn child, that there were treatment options available, or that she should consult with a perinatologist. According to S.G., Dr. Tendai said and did nothing to inform her of her treatment options or to care for the unborn child.

The AHC found that Dr. Tendai evidenced a general lack of disposition to use a present ability to perform a given duty. (Commission's Findings of Fact and Conclusions of Law, p. 18)(L.F. 290) This is a finding of fact made by the AHC. This Court must defer to the factual findings of the AHC as trier of fact. Dr. Tendai's claim that he gave S.G. all of the correct advice and that she was noncompliant was rejected by the AHC as a factual matter. Therefore, the AHC was well within the bounds of the trial evidence in finding that Dr. Tendai had demonstrated the lack of a disposition to treat patient S.G.'s condition of IUGR. In consideration of the facts of this specific case, the term "incompetency" is not constitutionally vague.

The *Duncan* court noted that the degree of harm or danger posed to the client can be considered in the calculus of whether a finding of "gross negligence" is appropriate under the facts. "The Commission could properly consider the potential of danger in determining the question of gross negligence. That which might constitute inadvertence where no danger exists may well rise to conscious indifference where the potential danger to human life is great." 744 S.W.2d at 540. As in the *Duncan* case, loss of life was a foreseeable outcome if Dr. Tendai did not carefully manage patient S.G.'s condition of IUGR. On the facts found by the Commission, it is difficult to imagine a more obvious example of conscious indifference to the safety of a patient and her baby.

Dr. Cameron felt that baby Mariah's death was preventable, testifying as follows:

> This baby didn't have to die. This was a preventable death. And by monitoring her properly, which would have taken some labor-intensive care, the death could have been foreseen, at least long enough to remove the baby by cesarian section, if necessary, and I am sure it would have been. And these babies usually, even with failure to grow in utero, when they are removed from that poisonous environment generally will thrive, and with proper nourishment, in about six months they will catch up with their - - the other babies of like age.

(Petitioner's Exhibit 1, Deposition of Dr. William Cameron, February 10, 1998, page 10, lines 10 to 20)(L.F. 785).

**(2) <u>Repeated negligence</u>**

Dr. Tendai attacks the definition of "repeated negligence" found in § 334.100.2(5): "'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." It should be noted that the definition provided in § 334.100.2(5) defines negligence in the exact same terms as M.A.I. 11.06, the definition used in a civil case involving allegations of negligence of a health care provider.[2]

The Board would submit that the term "repeated negligence" as defined in the statute is clear in meaning to the average person, once the term "negligence" is specifically defined. Dr. Tendai wants to focus on the word "occasion" as the touchstone for determining the meaning of "repeated negligence." The legislature used the term "repeated negligence" and did not see fit to build in limitations such as requiring nelgigence as to more than one patient in order to constitute "repeated negligence."

The Administrative Hearing Commission found under Count III of the First Amended Complaint that Dr. Tendai had been guilty of "repeated negligence" in his treatment of patient S.G. (Commission's Findings of Fact and Conclusions of Law, p. 21-22)(L.F. 293-94) The

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[2]"The term 'negligent' or 'negligence' as used in this [these] instruction[s] means the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of defendant's profession." (M.A.I. 11.06)

Commission found negligence at patient visits on November 2, November 9, November 16, and November 23, 1992. (Id.) The Commission found that on each of these visits that Dr. Tendai found no growth or, on November 23, 1992, minimal growth, "yet Tendai did not refer her to a perinatologist or conduct testing or deliver the baby." (Commission's Findings of Fact and Conclusions of Law, p. 22, L.F. 294). "Repeated negligence" is defined in Section 334.100.2(5), RSMo Supp.1992, as "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 (sic) of the applicant's or licensee's profession[.]"

Dr. Tendai cites no Missouri case law supporting his proposition that "repeated negligence" requires multiple patients. It appears to require multiple occasions rather than multiple patients. The Commission clearly had a substantial basis for finding negligence by Dr. Tendai on more than one occasion. Every time he tested patient S.G. for new growth in her fetus, found no growth, and then did nothing, he was negligent. As noted by the Commission, Dr. Tendai did this several times in the month of November, 1992. Count III of the First Amended Complaint based on "repeated negligence" is supported by substantial evidence of record.

The Board's First Amended Complaint clearly puts Dr. Tendai on notice that the Board raises multiple issues of negligence with respect to Count I (patient S.G.) (L.F. 00018) Count III of the First Amended Complaint incorporates all of the paragraphs of Count I and Count II specifically. (L.F. 0018) Count I refers to several different instances of negligence. (L.F. 00013-16). The Board adequately pleaded that Dr. Tendai was guilty of "repeated negligence"

in his treatment of patient S.G.

Dr. Tendai objects to the Administrative Hearing Commission's application of § 334.100.2(5), RSMo, to Dr. Tendai's care and treatment of S.G. Specifically, Dr. Tendai believes the record showed facts involving one patient, being treated for one condition, during the same course of treatment, within a limited time-frame; and, as such, it was impermissible for the AHC to conclude that Dr. Tendai's conduct constituted "repeated negligence" under § 334.100.2(5). The Board disagrees with this position and asserts that the AHC's application of the statute was proper and consistent with the overall purpose of Chapter 334, RSMo.

Section 334.100.2(5), RSMo, states that the Board may seek authority to hold a disciplinary hearing when:

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

Here, the Legislature has provided a definition of "the failure, on more than one occasion, to use that degree of skill and learning ordinarily used . . . ." In other words, there

must be a breach in the appropriate standard of care and that breach must take place "on more than one occasion." However, Dr. Tendai's conclusion that the AHC's definition of "occasion" is impermissible is not correct.

The primary purpose of the statutes authorizing the Board to discipline a physician's license is to safeguard the public health and welfare. *State Bd. of Registration for the Healing Arts v. Levine*, 808 S.W.2d 440, 442 (Mo.App. W.D.1991). Because the statutes are remedial and not penal in nature, they should be liberally construed. *Bittiker v. State Bd. of Registration for the Healing Arts*, 404 S.W.2d 402, 405 (Mo. App. W.D. 1966). Under accepted rules of statutory construction, words in statutes are given their "plain and ordinary meaning," as derived from the dictionary. *Abrams v. Ohio Pacific Exp.*, 819 S.W.2d 338, 340 (Mo. 1991); *Trailiner Corp. v. Director of Revenue*, 783 S.W.2d 917, 920 (Mo. banc 1990); Section 1.090, RSMo. "Courts have no authority to read into a statute a legislative intent which is contrary to the intent made evident by the plain and ordinary language of the statute." *Baldwin v. Director of Revenue, State of Mo.*, 38 S.W.3d 401, 2000 WL 818908, *3 (Mo.App. W.D. 2000), *citing*, *Kearney Special Road Dist. v. County of Clay*, 863 S.W.2d 841, 842 (Mo. banc 1993). "The legislature is 'presumed to have intended what the statute says; consequently, when the legislative intent is apparent from the words used and no ambiguity exists, there is no room for construction.'" *Moran v. Kessler*, 41 S.W.3d 530, 534 (Mo.App. W.D. 2001). There is no room for construction where words are plain and admit to but one meaning. *State ex rel. Missouri State Board of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219, 224 (Mo. banc 1986).

Occasion is defined by The American Heritage College Dictionary as: "1a) An event or a happening; an incident. 1b) The time at which an event occurs. 2) A significant event. 3) A favorable or appropriate time or juncture; an opportunity." THE AMERICAN HERITAGE COLLEGE DICTIONARY 943 (Third ed.1997). The Board believes this definition is sufficiently clear that further statutory construction is not warranted and, based on the facts presented to the AHC, justified a determination of repeated negligence here.

The AHC made the following determinations: 1) "Tendai violated the standard of care after November 2, 1992, by failing to refer the patient to a pertinatologist or by failing to conduct tests and deliver the baby after its lungs reached maturity;" and 2) "Tendai's conduct caused or contributed to the stillbirth of the baby."(Commission's Findings of Fact and Conclusions of Law, p.17-18)(L.F. 289-90). The AHC concluded that this conduct constituted gross negligence. (Commission's Findings of Fact and Conclusions of Law, p.17-18)(L.F. 289-90). The AHC also found as part of its findings of fact that Dr. Tendai treated S.G. on November 9, November 16, and November 23, after he was deemed to have been in breach of the standard of care. The AHC found that S.G.'s "fundus showed no growth on November 2, 9, 16, and minimal growth on November 23, yet Tendai did not refer her to a perinatalogist or conduct testing and deliver the baby." (Commission's Findings of Fact and Conclusions of Law, p.3-6, 22)(L.F. 275-78, 294) In other words, on three separate and discreet occasions, Dr. Tendai examined and treated S.G. and on three separate and discreet occasions, Dr. Tendai failed to follow the applicable standard of care. He failed to take the appropriate steps needed to treat the condition of IUGR on three separate occasions.

Dr. Tendai argues that § 334.100.2(5), RSMo, implies a time-frame of more than one week. First, § 334.100.2(5) does not expressly require any time-frame. Dr. Tendai suggests that under the AHC's interpretation a physician would risk discipline for repeated negligence for "misdiagnosing the same patient regarding the same ailment twice in the same two-minute office visit." Not only is the illustration ludicrous as conceded by Dr. Tendai, it is contrary to the plain and ordinary meaning of the term "occasion." The occasion would not be each failure to diagnose, but each event, each time, each date, each opportunity during which the physician committed a breach of the applicable standard of care.

Dr. Tendai offers no case law to directly support his position that repeated negligence could not exist here as a matter of law. In fact, the one case that appears to come closest to contemplating this issue, *Dorman v. Board of Registration for the Healing Arts*, 62 S.W. 3d. 446 (Mo.App. W.D. 2001), supports the Board's position. In the *Dorman* case, a physician was disciplined based on his failure to properly treat a patient over approximately a one-month period. The patient was having heart trouble and eventually was diagnosed as having suffered an acute myocardial infarction, which ultimately led to his death. The Western District approved, *sub silentio*, the AHC's finding of repeated negligence in the treatment of one patient during several visits over a period from December 9 to December 24. 62 S.W.3d at 451-52.

The basic thrust of the Healing Arts Practice Act is that one act of negligence on one occasion is not a basis for discipline. The Legislature has proceeded on the common sense understanding that even the most conscientious physician can make a mistake. Thus, "repeated

negligence" or "gross negligence" is necessary to justify disciplinary action by the Board. The Board would submit that this case illustrates the proper operation of the statute. Had Dr. Tendai but one instance of simple negligence in his care of patient S.G., disciplinary action would not have been appropriate. However, Dr. Tendai repeatedly examined patient S.G., repeatedly found that the fetus had not grown, and repeatedly did nothing about it. This course of conduct occurred over a period of 26 days before the baby finally died in the womb. Dr. Tendai had multiple opportunities to do the right thing but on no occasion did he do so. Dr. Tendai was repeatedly negligent over a period of almost a month. The Commission had an adequate basis for its finding of "repeated negligence" on Count III.

**(3) <u>Conduct harmful to the health of a patient</u>**

Dr. Tendai contends that the cause of baby Mariah's death was "because the baby's cord was wrapped around its neck and strangled the baby. (Brief of Appellant, page 69). The autopsy conducted revealed that "[i]ntrauterine fetal death was most likely due to the <u>combined effects</u> of a tight nuchal cord with severe chronic villitis of unknown etiology involving the placenta <u>with associated intrauterine fetal growth retardation</u>." (Petitioner's Exhibit 3; Necropsy Report, dated January 20, 1993)(L.F. 1370)(emphasis supplied). Dr. Tendai therefore incorrectly represents the results of the autopsy as attributing the death only to strangulation by the cord. Additionally, as set out above, Dr. Cameron testified that the death of baby Mariah could have been prevented by proper monitoring. (Petitioner's Exhibit 1, Deposition of Dr. William Cameron, February 10, 1998, page 10, lines 10 to 20)(L.F. 785).

Q. "Is there anything in the record that shows any activity by Dr.

Tendai at all with respect to taking some measures to help this lady's condition.

A. None."

(Petitioner's Exhibit 1, Deposition of Dr. William Cameron, February 10, 1998, page 18, lines 14 to 17)(L.F. 785).

There was substantial evidence from which the AHC could have concluded, as it did, that baby Mariah's death was preventable. Therefore, the AHC's finding that Dr. Tendai was guilty of conduct harmful to the health of a patient was fully supported by the record.

**(4) Section 334.100.2(5) is clearly constitutional as applied by the AHC**

Section 334.100.2(5) is clearly constitutional and provided due process to Dr. Tendai under the facts of this case. Dr. Tendai totally ignored patient S.G.'s condition of IUGR. He offered her no treatment and made no referral to a physician who could treat her. As a result, patient S.G.'s baby died unnecessarily. Dr. Tendai violated the applicable standards of care and was thus negligent. The Commission justifiably characterized his conduct as "incompetence," "gross negligence," "repeated negligence," and conduct harmful to the health of a patient.

**II. THE ADMINISTRATIVE HEARING COMMISSION DID NOT ERR IN FINDING THAT DR. TENDAI HAD VIOLATED SECTION 334.100.2(5), RSMo, IN THAT DR. TENDAI'S TREATMENT OF PATIENT S.G. VIOLATED THE APPLICABLE STANDARDS OF CARE.**

**Standard of Review**

The Board hereby incorporates the Standard of Review as set forth in Point 1, above.

**(1) Factual Overview**

In the present case, both the Commission Findings and the Board Disciplinary Order are supported by competent and substantial evidence upon the whole record, are not arbitrary, capricious or unreasonable, were entered in accordance with applicable Missouri law and procedure, and do not involve an abuse of discretion. Dr. Tendai's basic argument, as set out in his Appellant's Brief, is that the Administrative Hearing Commission incorrectly accepted the Board's evidence as credible, as against his own unsubstantiated, self-serving testimony. As this Court is well aware, witness credibility determinations are for the Commission, not for a court on judicial review. *State ex rel. Drury Displays, Inc. v. City of Olivette*, 976 S.W.2d 634, 635 (Mo. App. E.D. 1998). Dr. Tendai's arguments are not meritorious. This Court should reject Dr. Tendai's appeal in its entirety.

The Commission found in Dr. Tendai's favor on Count II of the First Amended Complaint. As will be seen, the Commission's findings of fact on Counts I and III were grounded in substantial and competent evidence.

In his Appellant's Brief, Dr. Tendai repeatedly refers to the "overwhelming" evidence that he properly advised patient S.G. about her condition of IUGR and what to do about it. In fact, however, the evidence supporting that proposition came solely from Dr. Tendai's own personal testimony. Dr. Tendai in his brief claims that "there are two sharply differing versions of the facts concerning Dr. Tendai's referral of S.G. to a perinatologist." (Brief of Appellant, page 56). In fact, the two sharply different versions of the facts were both put

forward by Dr. Tendai. Shortly after the event, he claimed that he had felt that the local perinatologist delivered babies too soon and he had felt that the best course of action was to attempt to carry the baby to term. At trial, he claimed that he had referred patient S.G. to a perinatologist but that she had refused to go.

Patient S.G. strongly denied in her testimony that Dr. Tendai had given her the claimed advice. The ongoing patient record did not contain a single instance of documentation by Dr. Tendai of his supposed advice to patient S.G. about this life-threatening condition. Of course, the "sticky notes" did purport to document Dr. Tendai's claimed advice to patient S.G. However, the Administrative Hearing Commission not surprisingly refused to consider the "sticky notes," at least partially based on the Commission's finding that one of the notes contained a comment on the fetus' "two-vessel cord," which was not discovered until the ultrasound at Cox South several weeks later.

A further factor was no doubt Dr. Tendai's tortured explanation of how the two "sticky notes" came to be created separately, then both lost, then both found, after his office submitted patient S.G.'s "flow chart" to the Board. (L.F. 599, line 15, to page 602, line 19)(Both "sticky notes" started, correctly filed, pulled back out, second entry made on "sticky note," then misfiled; same sequence of events with each "sticky note.") Most important to the Commission in making its factual findings rejecting Dr. Tendai's trial testimony might well have been the testimony of Board Investigator Bryan K. Hutchings.

Investigator Hutchings testified in rebuttal that he interviewed Dr. Tendai on April 6, 1993, and that he advised Dr. Tendai of the details patient S.G.'s complaint. (Testimony of

Bryan K. Hutchings, Trial Transcript, page 478, lines 14 to 18)(L.F. 766). This interview took place only three or four months after the demise of patient S.G.'s baby. Investigator Hutchings testified that he presented Dr. Tendai with a release signed by patient S.G. to allow the Board to have copies of her medical records. (Id. at p. 477, line 17-24)(L.F. 765). Investigator Hutchings testified that Dr. Tendai did not make any claim that he had made recommendations to patient S.G. which patient S.G. refused to follow. (Id. at p. 479, lines 3 to 23)(L.F. 767). Instead, Investigator Hutchings testified that Dr. Tendai indicated that at the time he felt that the best course of action for patient S.G. was to carry her baby to term. (Id. at p. 479, lines 3 to 23)(L.F. 767). Investigator Hutchings stated that Dr. Tendai indicated disagreement with the practice of immediate delivery of IUGR babies which Dr. Tendai indicated to Investigator Hutchings was the standard approach of the local perinatologist. (Id. at page 480, lines 2 to 8)(L.F. 768).

Dr. Tendai's statements to Investigator Hutchings within three or four months after the event are of course completely at odds with his later explanations of his conduct toward patient S.G. The Board would submit that Investigator Hutchings' trial testimony would provide a good basis for the Commission's rejection of Dr. Tendai's testimony of the actions toward patient S.G and her purported noncompliance with his alleged advice and instructions. The Administrative Hearing Commission dismissed Dr. Tendai's later version of the facts, noting that he had "changed his story" after his interview with Investigator Hutchings. (AHC, Findings of Fact and Conclusions of Law, p. 7, ftnt. 4, L.F. 279). The AHC had every right to accept the testimony of Investigator Hutchings as more credible than

Dr. Tendai's testimony.

The Commission made the specific finding that the "sticky notes" Dr. Tendai presented in evidence to support his defensive testimony were made after the fact. The AHC specifically found that the "sticky notes" appeared to have been made up after the fact and did not reflect the true course of events in patient S.G.'s care. (AHC, Findings of Fact and Conclusions of Law, p. 7, ftnt. 4)( L.F. 279). Such a state of facts brings to mind the maxim, *falsus in uno, falsus in omnibus*, which, if strictly applied, means that when a witness has testified falsely to any one material fact his testimony as a whole should be disregarded. As stated in *Bush v. Kansas City Public Service Co.*, 350 Mo. 876, 169 S.W.2d 331, 334 (Mo. 1943): "The falsehood which will authorize the disregarding of a witness' testimony must be as to a material matter, or at least as to a matter which the witness believes to be material, and a witness is not to be discredited because of a discrepancy, or contradiction, or even deliberate falsehood as to an irrelevant or immaterial matter." The AHC clearly found Dr. Tendai to be guilty of a significant and material falsehood. The AHC was certainly justified in disregarding his entire testimony.

It is elementary that the assessment of credibility of witnesses is a matter for the board hearing the testimony, and on review an appellate court must defer to its findings in that regard. *Ross v. Robb*, 662 S.W.2d 257, 260 (Mo. banc 1983); *Perez v. Bd. of Reg. for the Healing Arts*, 803 S.W.2d 160, 165 (Mo. App. W.D. 1991). The Administrative Hearing Commission simply found the testimony of patient S.G. more credible than the testimony of Dr. Tendai. This Court has no basis to upset that factual finding.

**(2) <u>On Count I, Dr. Tendai Negligent in Failure to Inform Patient S.G. of IUGR and In Failure to Monitor the Procession of Failure to Thrive Indexes with Nonstress Tests and Otherwise</u>**

**(a) <u>The Factual Background</u>**

Dr. Tendai, practicing as an obstetrician/gynecologist in Springfield, Missouri, saw a pregnant patient S.G. for the first time on April 14, 1992. (Petitioner's Exhibit 3, Respondent's office medical records for patient S.G.)(L.F. 1356-57). Dr. Tendai estimated the gestational age of patient S.G.'s fetus as four to six weeks. (Id.) Monthly visits continued through September 21, 1992. (Id.) During this time frame, the only abnormality, complication, or problem noted by Dr. Tendai was that patient S.G. tested positive for chlamydia. (Id.) Patient S.G. was treated for this condition. (Id.) Following the September 21, 1992 monthly visit, patient S.G saw Dr. Tendai every other week. (Id.)

On October 16, 1992, after an in-office ultrasound, Dr. Tendai suspected the fetus had intrauterine growth retardation (IUGR). (Id.) IUGR is a potentially life-threatening problem for the fetus but the treatment for IUGR is well-established and adequate treatment and management normally addresses the problem in most cases. (Petitioner's Exhibit 1, Deposition of Dr. William Cameron, page 9, line 19 to page 10, line 20)(L.F. 784-85). At that time, on October 16, 1992, patient S.G. was instructed by Dr. Tendai to have an ultrasound performed at Cox South Hospital in Springfield, Missouri. This ultrasound was performed on November 2, 1992. (Petitioner's Exhibit 3, Report of Radiological Consultation, dated January 25, 1993)(L.F. 1361). The radiologist's opinion was that the fetus had IUGR and the radiologist

also noted that a two-vessel umbilical cord was present instead of the normal three-vessel cord. (Id.)

After receiving the results of the Cox ultrasound, Dr. Tendai diagnosed a condition of IUGR. (Testimony of Dr. Tendai, Trial Transcript, page 231, line 15 to line 25)(L.F. 521). According to patient S.G., Dr. Tendai never so much as mentioned IUGR and patient S.G. unequivocally testified that Dr. Tendai did not refer her to a perinatologist or any other specialist. (Petitioner's Exhibit 2, Deposition of patient S.G., April 2, 1998, page 16, line 1 to page 17, line 2)(L.F. 851-52). Dr. Tendai did not recommend more frequent monitoring. (Id.) Dr. Tendai did not recommend amniocentesis. (Id. at page 69, lines 17 to 19)(L.F. 903). Dr. Tendai did not indicate to patient S.G. that there was a problem with her baby. (Id. at page 68, line 20 to page 70, line 9)(L.F. 902-04) Patient S.G. just thought that she was going to have a small baby but she did not consider this to be a critical problem. (Id. at page 22, lines 2 to 12)(L.F. 857). Nobody told her that this could be a serious problem. (Id. at page 15, lines 20 to 25)(L.F. 850). According to patient S.G., at no time after this ultrasound did Dr. Tendai suggest to S.G. that a visit to a perinatologist would be wise under the circumstances. (Id. at page 22, lines 2 to 12)(L.F. 857).

On November 28, 1992, late in the evening, patient S.G. went to Cox South Hospital and complained that she had not felt any fetal movement for about twenty-four hours. (Petitioner's Exhibit 3, Respondent's office medical records for patient S.G.)(L.F. 1354-1454)(1413 (Admission and Labor Chart)(1452)(Birth Certificate)(1444)(Newborn Record)(1420)(Delivery Chart Record). No fetal heart tones were detected. (Id.) After an

ultrasound, patient S.G. was transferred to the delivery room and delivered baby Mariah, a stillborn child. (Id.) Dr. Tendai was not present. (Id.) Twenty-six days elapsed after Dr. Tendai's formal diagnosis of IUGR and fetal demise on November 28, 1993. During this 26-day period, Dr. Tendai took no steps whatsoever to treat or manage patient S.G.'s condition of IUGR. (Id.)

The autopsy conducted revealed that "[i]ntrauterine fetal death was most likely due to the combined effects of a tight nuchal cord with severe chronic villitis of unknown etiology involving the placenta with associated intrauterine fetal growth retardation." (Petitioner's Exhibit 3; Necropsy Report, dated January 20, 1993)(L.F. 1370). The report went on to state that "[u]mbilical artery thrombosis is a common finding in placental vessels of stillborns. Other findings included a two- vessel umbilical cord. Although the two-vessel umbilical cords are associated with an increased incidence of fetal congenital malformations, no other congenital malformations are identified." (Id.)

**(b) <u>The Findings of the Administrative Hearing Commission</u>**

With respect to Dr. Tendai's treatment of patient S.G., as set out in Count I of the Board's First Amended Complaint, such conduct was found by the Administrative Hearing Commission to constitute gross negligence, incompetence, and conduct harmful to a patient under Section 334.100.2(5), RSMo, in that Dr. Tendai recognized the problem of IUGR, but failed after November 2, 1992, to take a practical course of action to counter the intrauterine growth retardation or, in the alternative, to refer patient S.G. to a perinatologist capable of doing so. (L.F. 294). The AHC also found that Dr. Tendai's treatment of patient S.G. amounted to

"repeated negligence" within the meaning of Section 334.100.2(5), RSMo, on Count III of Petitioner's First Amended Complaint. (Id.) The record demonstrates that the AHC based its decision on substantial and competent evidence upon the whole record. This Court should sustain and uphold the AHC's findings.

**(c) <u>The Expert Testimony</u>**

According to the testimony of the Board's expert witness, Dr. William Cameron, M.D., Dr. Tendai diagnosed IUGR but failed to initiate any kind of measure "to monitor the procession of failure to thrive indexes." (Petitioner's Exhibit 1, Deposition of Dr. William Cameron, February 10, 1998, page 9, line 19 to page 11, line 6)( L.F. 784-86). Dr. Cameron testified that no monitoring was done, Dr. Cameron indicating that monitoring could have been done by biophysical profile, which includes an ultrasound and nonstress testing to assess the activity of the baby in response to movement and/or to look for fetal heart activity. (Id. at page 16, line 24 to page 17, line 14)(L.F. 791-92). Dr. Cameron testified that twice-weekly biophysical monitoring was required by the standard of care as well as twice-weekly nonstress testing. (Id.) Dr. Tendai's own expert witness, Dr. William T. Griffin, M.D., concurred with Dr. Cameron that, based on his initial review of the ongoing patient record, nonstress testing could have and should have been done by Dr. Tendai and that his failure to do so violated the standard of care. (Testimony of Dr. William Griffin, Trial Transcript, page 381, line 23 to page 382, line 6)(L.F. 669-70).

Dr. Tendai violated the applicable standards of care in his treatment of patient S. G. Dr. Tendai failed to refer patient S.G. to a perinatologist. Dr. Tendai testified that he did not have

the equipment to conduct a nonstress test in his office in 1992, at the time patient S.G. needed nonstress testing. (Testimony of Respondent, Trial Transcript, page 236, lines 6 to 13)(L.F. 526). Therefore, Dr. Tendai had a duty to refer patient S.G. to a physician such as a perinatologist who had the means and ability to conduct the required testing. Although Dr. Tendai claims to have made such a recommendation to patient S.G., patient S. G. denies that such a recommendation was made and Dr. Tendai's patient records for patient S.G. do not document such a referral. (Petitioner's Exhibit 3, Respondent's office medical records for patient S.G.)(L.F. 1353-1454).

In particular, Dr. Tendai's own medical expert, Dr. William T. Griffin, M. D., testified that his review of the medical record demonstrated that adequate fetal monitoring was not conducted after the diagnosis of IUGR was made by Dr. Tendai. (Testimony of Dr. William Griffin, Trial Transcript, page 381, line 23, to page 382, line 6)(L.F. 669-70).

Based on the medical record and according to Dr. Griffin's testimony, Dr. Tendai violated the applicable standard of care in his treatment of patient S. G. by failing to refer patient S.G. to a perinatologist or other physician capable of providing patient S.G. with appropriate care, to-wit: administering nonstress testing two times per week. Dr. Griffin did testify in answer to counsel's question that, assuming Dr. Tendai had repeatedly told patient S.G. that she needed to go see a perinatologist, then Dr. Tendai would have met the standard of care. (Testimony of Dr. William Griffin, Trial Transcript, page 387, line 21, to page 388, line 21)(L.F. 675-76). Of course, the Commission rejected Dr. Tendai's factual testimony on this point.

Dr. Tendai failed to discuss the results of the ultrasound done at Cox with patient S.G. and failed to advise patient S.G. of his diagnosis of IUGR and the ramifications of such diagnosis and the treatment options available to patient S.G. (Petitioner's Exhibit 2, Deposition of patient S.G., April 2, 1998, page 22, lines 2 to 12)(L.F. 857). Dr. Tendai's failure to discuss the results of the ultrasound done at Cox with patient S.G. in itself constituted a violation of the applicable standard of care. (Testimony of Dr. William Griffin, Trial Transcript, page 420, line 2, to line 17)(L.F. 708).

Dr. Cameron felt that baby Mariah's death was preventable, testifying as follows:

> This baby didn't have to die. This was a preventable death. And by monitoring her properly, which would take some labor-intensive care, the death could have been foreseen, at least long enough to remove the baby by cesarean section, if necessary, and I am sure it would have been. And these babies usually, even with failure to grow in utero, when they are removed from that poisonous environment generally will thrive, and with proper nourishment, in about six months they will catch up with their - - the other babies of like age.

(Petitioner's Exhibit 1, Deposition of Dr. William Cameron, February 10, 1998, page 10, lines 10 to 20)(L.F. 785).

**(d) <u>Dr. Tendai Defends His Conduct by Claiming Patient Noncompliance–the "Sticky Notes"</u>**

Count I of the First Amended Complaint essentially boiled down to whether the Commissioner believed Dr. Tendai or whether, on the other hand, she believed patient S.G. Dr. Tendai testified that he fully advised patient S.G. of her condition of IUGR and the available treatment options but that patient S.G. repeatedly refused to follow his recommendations. (Testimony of Dr. Tendai, Trial Transcript, page 235, lines 1 to 6; page 238, lines 13 to 19)(L.F. 525-28). Patient S.G. testified that Dr. Tendai at no time discussed her condition of IUGR or presented her with any recommendations or treatment options. (Petitioner's Exhibit 2, Deposition of patient S.G., April 2, 1998, page 22, lines 2 to 12)(L.F. 857). The ongoing patient medical record does not document that Dr. Tendai discussed IUGR with patient S.G. or provided her with any recommendations or treatment options. (Petitioner's Exhibit 1, Deposition Transcript of Dr. William Cameron, February 10, 1998, page 17, lines 15 to 17 (L.F. 792); Petitioner's Exhibit 3, Respondent's office medical record for patient S.G.(L.F. 1353-1454)).

Dr. Tendai offered into evidence two "sticky notes" which were allegedly a part of the ongoing patient record and which purported to document appropriate advice as to IUGR by Dr. Tendai and a refusal of Dr. Tendai's advice by patient S.G. However, the Court should note that the "sticky notes" were not presented to the Board when copies of all of patient S.G.'s medical files were requested from Dr. Tendai. (Testimony of Bryan K. Hutchings, Trial Transcript, page 479, line 1 through 3 (L.F. 767); Testimony of Dr. Tendai, Trial Transcript, page 298, line 19 to page 299, line 24; page 248, lines 4 to 19 (L.F. 587-88; L.F. 538)). Further, Dr. Tendai did not provide or even mention the existence of the "sticky notes" when interviewed by the Board's

investigator Bryan K. Hutchings on April 6, 1993. (Testimony of Bryan K. Hutchings, Trial Transcript, page 479, lines 1 to 3)(L.F. 767). Dr. Tendai claimed that both "sticky notes" were misfiled and recovered some time after he initially provided S.G.'s patient records to the Board. (Testimony of Dr. Tendai, Trial Transcript, page 302, line 2, to page 305, line 6)(L.F. 591-94).

It is worth noting that Dr. Tendai's own expert witness, Dr. William T. Griffin, M.D., at first refused to consider the "sticky notes" as Dr. Griffin did not consider the "sticky notes" as part of the official medical record on patient S.G. (Testimony of Dr. William Griffin, Trial Transcript, page 414, lines 7 to 12)(L.F. 702).

**(e) The Administrative Hearing Commission finds that Dr. Tendai made up evidence--Dr. Tendai's defensive "sticky notes" added to record after the fact**

The Administrative Hearing Commission specifically found that the "sticky notes" appeared to have been made up by Dr. Tendai "after the fact." (AHC Findings of Fact and Conclusions of Law, page 7, footnote 4)(L.F. 279). The Commission stated:

> Tendai argues that he did refer S.G. to a perinatologist, but that she was in denial and refused to go to a perinatologist. We find that he did not refer her to a perinatologist because he believed that the perinatologist delivered babies too early, and he decided that the best course of action would be to attempt to carry the baby to term. Our finding is based on the testimony of the Board's investigator; to whom Tendai gave this explanation when the Board began its investigation (Tr. at 480 and on S.G.'s Testimony by

> videotaped deposition. Tendai then changed his story and argued that he found "sticky notes" pertaining to S.G. that had been mistakenly placed in another file. He argues that he wrote personal matters on the "sticky notes" and that the "sticky notes" detail S.G.'s reaction to his diagnosis and her refusal to see a perinatologist. We do not find this explanation believable, as the "sticky notes" appear to have been written after the fact. For example, the "sticky note " entry for October 16, 1992, states that the fetus possibly had a two-vessel cord, when the chart for the same date indicates that a three-vessel cord, and a two-vessel cord was not revealed until the hospital ultrasound on November 2, 1992.

(Commission Findings, page 7, footnote 4)(L.F. 279).

Except for Dr. Tendai's own personal testimony, there was no evidence in the record to support a finding by the Commission of patient noncompliance by patient S.G. Dr. Tendai's expert witness, Dr. Griffin, testified that his review of the patient record did not disclose any instance of documented patient noncompliance by patient S.G. (Testimony of Dr. William Griffin, Trial Transcript, page 460, line 24, to page 461, line 3)(L.F. 748-49). Reinforced by the absence of documentation by Dr. Tendai that he made the proper recommendations and that patient S.G. refused his advice, the Commission found credible patient S.G.'s testimony that Dr. Tendai failed to discuss IUGR with her and further failed to provide her with treatment

alternatives and options. Patient S.G. credibly testified that Dr. Tendai at no time indicated to her that the small size of her baby presented any serious medical problem. (Petitioner's Exhibit 2, Deposition of Patient S.G., April 2, 1998, page 22, lines 2 to 12)(L.F. 857). Patient S.G., a very young woman of limited education and sophistication, credibly testified that she believed that she simply had a small baby and that the small size of her baby did not present a significant medical problem. (Id.) The record supports the testimony of patient S.G. that Dr. Tendai made no mention to her of IUGR or suggested any treatment alternatives to her and the Commission so found.

**(f) Dr. Tendai Never Mentions Patient Noncompliance in Interview with Board Investigator - - Claims Felt it Best to Allow Pregnancy to Proceed Uninterrupted**

The Board's investigator Bryan K. Hutchings testified in rebuttal that he interviewed Dr. Tendai on April 6, 1993, and advised Dr. Tendai of the details of patient S.G.'s complaint. (Testimony of Bryan K. Hutchings, Trial Transcript, page 478, lines 12 to 18)(L.F. 766). Investigator Hutchings testified that he presented Dr. Tendai with a release signed by patient S.G. to allow the Board to have copies of all of her medical records. (Id. at p. 477, lines 19-23)(L.F. 765) Investigator Hutchings testified that Dr. Tendai did not in that interview make any claim that he had made recommendations to patient S.G. which patient S.G. refused. (Id. at lines 3 to 23). Instead, Investigator Hutchings testified that Dr. Tendai indicated that at the time he felt that the best course of action for patient S.G. was to carry her baby to term. (Id. at lines 21 to 23)(L.F. 767). Investigator Hutchings indicated that Dr. Tendai indicated disagreement with the practice of immediate delivery of IUGR babies which Dr. Tendai

indicated to Investigator Hutchings was the standard approach of perinatologists. (Id. at page 480, lines 2 to 8)(L.F. 768). According to Investigator Hutchings, Dr. Tendai repeatedly referred to the perinatologist in question as "she." (Id. at lines 11 to 15). It is noted that Dr. Tendai usually referred patients to Dr. Patricia Dix, a female perinatologist at Cox Medical Center. (Testimony of Respondent, Trial Transcript, page 321, lines 3 to 5)(L.F. 610). Dr. Dix was apparently the only perinatologist in the Springfield area to accept Medicaid patients, according to Dr. Tendai. (Id. at lines 11 to 13).

On cross-examination, Dr. Tendai's counsel inquired of Investigator Hutchings as to whether he had "a list of questions that you asked him." (Id., page 482, line 24, to line 25)(L.F. 770). Investigator Hutchings indicated that he had. Investigator Hutchings was asked if he had brought those questions to the hearing and he indicated that he had. (Id., page 483, line 2, to line 3)(L.F. 771). Investigator Hutchings further indicated during cross-examination that he had written down Dr. Tendai's answers during the interview. (Id., page 483, line 6, to line 7)(L.F. 771). Investigator Hutchings did therefore have available at trial his personal notes from his interview with Dr. Tendai conducted on April 6, 1993. Investigator Hutchings' testimony was based on his memory and his contemporaneous notes. Investigator Hutchings' trial testimony was therefore extremely credible. Dr. Tendai in his brief makes the misleading claim that Investigator Hutching's notes of his interview were not offered in evidence. It should be noted that counsel for Dr. Tendai, after establishing in cross-examination that Investigator Hutchings had brought his contemporaneous notes to trial, never pursued the matter further.

If patient S.G. repeatedly failed and refused to follow his advice and recommendations, as claimed by Dr. Tendai, resulting in the death of her baby, it would seem probable that this would have been mentioned by Dr. Tendai when interviewed by Board Investigator Bryan Hutchings. Dr. Tendai claims that he repeatedly begged his patient to take measures to save her baby but that she flatly refused and the baby died. One would not think that this sort of thing happens to a physician just every day and that such an outcome would be memorable.

Dr. Tendai's failure to mention the supposed patient noncompliance in his interview with the Board's investigator strongly suggests that Dr. Tendai's claims of patient noncompliance constitute merely an after-the-fact justification for his failure to properly care for the patient. If patient S.G. had in fact repeatedly failed and refused to follow his advice and her baby had died because of that, Dr. Tendai would surely have reported this to the Board investigator interviewing him about patient S.G.'s complaint to the Board. Dr. Tendai wanted the Commission to believe that he was hauled before the Board by patient S.G. after the death of her baby, accused of negligence, his records demanded, and his statement taken by a Board investigator, but that patient S.G.'s purported total refusal to follow his advice and guidance–slipped his mind? The Commission found Dr. Tendai's testimony not to be credible and it is simply not very hard to understand why.

**(2) <u>Summary of Evidence Under Count I - - the Board has Presented Substantial Evidence Justifying Discipline of Dr. Tendai's License</u>**

Dr. Tendai suspected IUGR on October 16, 1992. (L.F. 516) Dr. Tendai confirmed IUGR on November 2, 1992, after an ultrasound at Cox Medical Center. Baby Mariah was born

dead on November 28, 1992. (Petitioner's Exhibit 3, Respondent's office medical record for patient S.G.)(L.F. 1353-1454; L.F. 1420, 1444, 1452, 1370). Dr. Tendai had a period of 26 days to try to manage S.G.'s condition of IUGR. Dr. Tendai took no steps whatsoever during this period to manage and treat the condition of IUGR. Dr. Tendai claimed that he gave the appropriate advice but that, for some unexplainable reason, patient S.G. refused his advice and let her baby die *in utero*. Patient S.G. adamantly disputed Dr. Tendai's version of events.

Patient S.G. testified credibly that Dr. Tendai never discussed treatment options for the IUGR condition. (Petitioner's Exhibit 2, Deposition of patient S.G., April 2, 1998, page 22, lines 2 to 12)(L.F. 857). Dr. Tendai's ongoing patient record does not support his testimony that he gave patient S.G. the proper advice but that she refused to follow his advice. (Petitioner's Exhibit 3, Respondent's office medical record for patient S.G.)(L.F. 1353-1454). The Board's investigator met with Dr. Tendai shortly after receiving patient S.G.'s complaint and Dr. Tendai failed to mention giving any advice such as a referral to a perinatologist and Dr. Tendai at no time suggested patient noncompliance. (Testimony of Bryan Hutchings, Trial Transcript, page 481, lines 1 to 23)(L.F. 769). When meeting with the Board's investigator, Dr. Tendai claimed that he felt the best course of action was just to ride out the pregnancy rather than refer patient S.G. to a perinatologist who would want to immediately deliver the baby. (*Id*. at page 479, line 21 to page 480, line 8)(L.F. 767-68). Even Dr. Tendai's own expert witness believes that the ongoing patient record discloses a violation of the applicable standard of care in Dr. Tendai's failure to conduct nonstress testing. (Testimony of Dr. William Griffin, Trial Transcript, page 381, line 23, to page 382, line 6)(L.F. 669-70).

The Board's expert found what he termed total neglect on the part of Dr. Tendai in the failure to implement any monitoring of the procession of failure to thrive indices. (Petitioner's Exhibit 1, Deposition Transcript of Dr. William Cameron, February 10, 1998, page 10, lines 4 to 6)(L.F. 785).

Dr. Tendai engaged in a course of conduct which was found by the Commission to be incompetent, grossly negligent and harmful and dangerous to the mental or physical health of the patient while in the performance of functions or duties of a profession regulated under Chapter 334, RSMO Supp. 1990-92. The Commission found that Dr. Tendai failed to use that degree of skill and learning ordinarily used under the same or similar circumstances by members of Dr. Tendai's profession. The Commission correctly found that Dr. Tendai's conduct as set out in Count I of the First Amended Complaint provided a basis for discipline by the Board under the provisions of Section 334.100.2(5). The Commission correctly found that Dr. Tendai's conduct as set out in Count III of the First Amended Complaint provided a basis for discipline by the Board under the provisions of Section 334.100.2(5) as constituting "repeated negligence."

Dr. Tendai makes much of the Commission's finding that Dr. Tendai failed to refer S.G. to a perinatologist because he felt that she tended to deliver babies too soon. Dr. Tendai apparently sees his inaction in the face of the IUGR condition as a good thing. If he had felt that he could not possibly make a referral to this particular perinatologist then he still had the professional duty to monitor the procession to thrive indices related to S.G.'s condition of

IUGR.[3] The Commission correctly found that Dr. Tendai had alternative courses of action which would have met the standard of care. "We conclude that Tendai violated the standard of care after November 2, 1992, by failing to refer the patient to a perinatologist or by failing to conduct tests and deliver the baby after its lungs reached maturity." (Commission's Findings of Fact and Conclusions of Law, p. 17-18).

The Commission's findings of fact are supported by substantial and competent evidence upon the whole record and are not arbitrary, capricious, or unreasonable. This Court should sustain the Board's Disciplinary Order and the Administrative Hearing Commission's Findings of Fact and Conclusions of Law and enter judgment for Respondent Board of Healing Arts on Dr. Tendai's Petition for Review.

**(Appellant's Points) (A) and (B) No standard of care evidence for doctor referring to perinatologist where the only one available does not agree with referring doctor's philosophy**

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[3]Even if Dr. Tendai is correct in his assertion that the perinatologist in question was the only perinatologist in the Springfield area who accepted Medicaid patients, he still had the option of trying to identify a qualified perinatologist in the general area (or the state of Missouri under Medicaid regulations) who would have accepted patient S.G. Although some Missouri physicians do not routinely accept Medicaid patients, it is difficult to believe that no qualified physician would agree to treat patient S.G. under the severe and dangerous circumstances she found herself in after Dr. Tendai diagnosed a condition of IUGR, Medicaid or no Medicaid.

As the Board understands Dr. Tendai's argument, he makes the claim that the Board did not present expert testimony as to the standard of care applicable when a referring physician has only one perinatologist available to make a referral and the referring physician does not agree with the philosophy of the available perinatologist as to the appropriate approach in that given situation.

Of course, the basic fallacy of this argument is that there was only one perinatologist available for Dr. Tendai to make a referral. Apparently, there is only one perinatologist in the Springfield area who accepts Medicaid reimbursement, patient S.G. being a Medicaid patient. Surely, Dr. Tendai was capable of finding a perinatologist within a reasonable distance who would have been willing to care for patient S.G. In any event, there was no proof in the record that other willing and qualified perinatologists were not available to see patient S.G.

Dr. Tendai had a duty to monitor and treat patient S.G.'s condition of IUGR. He either had a duty to do the necessary tests himself or, in the alternative, to make a referral to a physician who could do the required testing. A perinatologist clearly would have been in a position to perform the nonstress testing and other measures necessary to monitor the fetus. That Dr. Tendai apparently felt that the readily available perinatologist had a tendency to deliver IUGR babies too soon, does not excuse him from his professional duty to either perform the requisite monitoring on patient S.G. himself or to make a referral to a physician who could. The Board presented expert testimony to this effect.

The Board ought not to 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. Dr. Tendai failed to make a referral and thereby retained the professional responsibility to comply with the standards of care applicable. Dr. Tendai failed to do so. His excuse is that he would have referred to a perinatologist to do the required testing, but that there was only one available, and that he did not agree with her philosophy. So he did nothing and the baby died. The Board presented expert testimony to the effect that you either perform the required tests or make a referral to have them performed. Dr. Tendai did neither. No other expert testimony was necessary.

Under Missouri law, a plaintiff is ordinarily bound by his own testimony and cannot submit on a factual theory fundamentally inconsistent with his own theory of the case and evidence. *Doisy v. Edwards*, 398 S.W.2d 846, 849 (Mo. 1966). This is known as the "at war" doctrine. *Id.* Under the "at war" rule, a plaintiff who presents one theory by positive evidence cannot recover on a theory supported only by the defendant's evidence which is directly contrary thereto. *Id.* It has been stated more generally that the submission of inconsistent and contradictory theories of recovery to a jury is error, notwithstanding that the rules of civil procedure authorize the pleading of claims or defenses in the alternative. *Wallace v. Bounds*, 369 S.W.2d 138 (Mo. 1963).

This principle would seem imminently applicable here. Dr. Tendai affirmatively testified that he advised patient S.G. to see a perinatologist but that she ignored his advice and refused to do so. The Commission failed to so find the facts. The Commission accepted patient S.G.'s testimony that Dr. Tendai never referred her to a perinatologist or took any other action in response to her condition of IUGR. Dr. Tendai still to this day is claiming that he

referred patient S.G. to a perinatologist but that patient S.G. failed to follow his advice. However, he wants the benefit of his other story, as told to Investigator Hutchings shortly after the incident (and presented at trial by the Board), that he felt that the local perinatologist tended to deliver IUGR babies too soon and that he felt that the best course of action was to simply attempt to try to carry the baby to term. Version No. 1 is obviously fundamentally inconsistent with Version No. 2. Dr. Tendai wants it both ways. If you don't believe Version No. 1, then what about Version No. 2?

Dr. Tendai cannot alternatively rely on two fundamentally inconsistent versions of events leading up to the death of baby Mariah and must be held to his own testimony and theory of the case. Unfortunately for Dr. Tendai, the Commission authoritatively rejected his testimony that he advised S.G. to see a perinatologist. He cannot then disavow his own testimony and adopt a theory of defense necessarily and fundamentally inconsistent with his own positive testimony and theory of the case. Put another way, the Board was under no obligation to present expert testimony as to whether Dr. Tendai complied with the standard of care by doing something that he adamantly testified under oath that he did not do. Counsel for Dr. Tendai in his opening statement discussed only Dr. Tendai's claim that he repeatedly advised patient S.G. to see a perinatologist. Counsel did not suggest an alternative version of the facts, to-wit, that Dr. Tendai did not make a referral to the perinatologist because he feared that she would deliver the baby before its lungs were mature. (Tr. 16-26)(L.F. 310-20). The Board had no obligation to present expert testimony related to a version of facts that Dr. Tendai denied.

Q. Isn't the truth, Doctor, with regard to [patient S.G.] and didn't you tell Bryan Hutchings when you talked to him that it was your medical opinion that the best thing for [patient S.G.] was to carry this baby to term rather than turn her over to a perinatologist who you felt would have immediately delivered the baby?

A. First part is correct. Second party is out of context by 180 degrees.

Q. You tell me.

A. That the ideal is to carry a pregnancy with IUGR as far towards term as possible to get not only whatever little bit of weight you might get on the baby but also lung maturity. As far as turning her over to a perinatologist that wanted to deliver her early, we're talking about one perinatologist, not perinatologists.

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Q. So the truth is, you felt that the best thing for her to do was to carry the baby to term. You also felt that you referred her to the only perinatologist you could refer her to, Dr. Dix, based on your knowledge of Dr. Dix's approach to things that she would have pulled the baby out wasn't that the best course of action; isn't that the truth?

A. No, it is not.

(Tr. 320-21)(L.F. 609-10). Dr. Tendai should not be able to alternatively rely on two fundamentally inconsistent versions of events and must be held to his own testimony and theory of the case. Section 334.100.2(5) cannot be held to be unconstitutionally vague based on a factual scenario which Dr. Tendai has for so long denied having occurred.

**(Appellant's Points) (C) and (D) "Repeated Negligence" under Section 334.100.2(5), RSMo**

The Administrative Hearing Commission found under Count III of the First Amended Complaint that Dr. Tendai had been guilty of "repeated negligence" in his treatment of patient S.G. (AHC, Findings of Fact and Conclusions of Law, p. 22, L.F. 294). The Commission found negligence at patient visits on November 2, November 9, November 16, and November 23, 1992. (Id.) The Commission found that on each of these visits that Dr. Tendai found no growth or, on November 23, 1992, minimal growth, "yet Tendai did not refer her to a perinatologist and/or conduct testing or deliver the baby." (AHC, Findings of Fact and Conclusions of Law, p. 22)(L.F. 294). "Repeated negligence" is defined in Section 334.100.2(5), RSMo Supp.1992, as "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 (sic) of the applicant's or licensee's profession[.]" (*Id*.)

Dr. Tendai cites no Missouri case law supporting his proposition that "repeated negligence" requires multiple patients. It appears to require multiple occasions rather than multiple patients. The Commission clearly had a substantial basis for finding negligence by

Dr. Tendai on more than one occasion. Every time he tested patient S.G. for new growth in her fetus, found no growth, and then did nothing, he was negligent. As noted by the Commission, Dr. Tendai did this several times in the month of November, 1992. Count III of the First Amended Complaint based on "repeated negligence" is supported by substantial evidence of record.

The Board's First Amended Complaint clearly puts Dr. Tendai on notice that the Board raises multiple issues of negligence with respect to Count I (patient S.G.) (L.F. 00018) Count III of the First Amended Complaint incorporates all of the paragraphs of Count I and Count I specifically. (L.F. 0018) Count I refers to several different instances of negligence. (L.F. 00013-16). The Board adequately pleaded that Dr. Tendai was guilty of "repeated negligence" in his treatment of patient S.G.

Dr. Tendai. objects to the Administrative Hearing Commission's (AHC) application of § 334.100.2(5), RSMo, to Dr. Tendai's care and treatment of S.G. Specifically, Dr. Tendai believes the record showed facts involving one patient, being treated for one condition, during the same course of treatment, within a limited time-frame; and, as such, it was impermissible for the AHC to conclude that Dr. Tendai's conduct constituted "repeated negligence" under § 334.100.2(5). The Board disagrees with this position and asserts that the AHC's application of the statute was proper and consistent with the overall purpose of Chapter 334, RSMo.

Section 334.100.2(5), RSMo, states that the Board may seek authority to hold a disciplinary hearing when:

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

Dr. Tendai is correct that the issue presented to the Court is straightforward; what does "repeated negligence" mean. Here, the Legislature has provided a definition of "the failure, on more than one occasion, to use that degree of skill and learning ordinarily used . . . ." In other words, there must be a breach in the appropriate standard of care and that breach must take place "on more than one occasion." However, Dr. Tendai's conclusion that the AHC's definition of "occasion" is impermissible is not correct.

The primary purpose of the statutes authorizing the Board to discipline a physician's license is to safeguard the public health and welfare. *State Bd. of Registration for the Healing Arts v. Levine*, 808 S.W.2d 440, 442 (Mo.App. W.D.1991). Because the statutes are remedial and not penal in nature, they should be construed liberally. *Bittiker v. State Bd. of Registration for Healing Arts*, 404 S.W.2d 402, 405 (Mo. App. W.D. 1966). Under accepted rules of statutory construction, words in statutes are given their "plain and ordinary meaning"

as derived from the dictionary. *Abrams v. Ohio Pacific Exp.,* 819 S.W.2d 338, 340 (Mo. 1991); *Trailiner Corp. v. Director of Revenue*, 783 S.W.2d 917, 920 (Mo. banc 1990); Section 1.090, RSMo. "Courts have no authority to read into a statute a legislative intent which is contrary to the intent made evident by the plain and ordinary language of the statute." *Baldwin v. Director of Revenue, State of Mo.*, 38 S.W.3d 401, 2000 WL 818908, *3 (Mo.App. W.D. 2000), citing, *Kearney Special Road Dist. v. County of Clay*, 863 S.W.2d 841, 842 (Mo. banc 1993). "The legislature is 'presumed to have intended what the statute says; consequently, when the legislative intent is apparent from the words used and no ambiguity exists, there is no room for construction.'" *Moran v. Kessler*, 41 S.W.3d 530, 534 (Mo.App. W.D. 2001). There is no room for construction where words are plain and admit to but one meaning. *State ex rel. Missouri State Board of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219, 224 (Mo. banc 1986).

Dr. Tendai argues that he was held responsible for repeated negligence when he merely was administrating "one course of continuing treatment of one patient for one condition." "So the AHC's finding of repeated negligence is based on Dr. Tendai's care of *one* patient, and one treatment – an examination, given during one week, for one condition – her pregnancy." This statement, however, unduly limits the AHC's findings.

The AHC made the following determinations: 1) "Tendai violated the standard of care after November 2, 1992, by failing to refer the patient to a perinatologist or by failing to conduct tests and deliver the baby after its lungs reached maturity;" and 2) "Tendai's conduct caused or contributed to the stillbirth of the baby." The AHC concluded that this conduct

constituted gross negligence.(AHC, p.17-18)(L.F. 289-90). The AHC also found as part of its findings of fact that Dr. Tendai treated S.G. on November 9, November 16, and November 23, after he was deemed to have been in breach of the standard of care. The AHC found that S.G.'s "fundus showed no growth on November 2, 9, 16, and minimal growth on November 23, yet Tendai did not refer her to a perinatalogist or conduct testing and deliver the baby." (AHC, p.3-6, 22)(L.F. 275-78, 294). In other words, on three separate and discreet occasions, Dr. Tendai examined and treated S.G. and on three separate and discreet occasions, Dr. Tendai failed to follow the applicable standard of care. He failed to realize that S.G.'s fetus was suffering from IUGR and to take the appropriate steps needed to treat the condition.

Dr. Tendai argues that § 334.100.2(5), RSMo, implies a time-frame of more than one week. First, § 334.100.2(5) does not expressly require any time-frame as offered by Dr. Tendai. Dr. Tendai suggestion that under the AHC's interpretation that physician would risk discipline for repeated negligence for "misdiagnosing the same patient regarding the same ailment twice in the same two-minute office visit. Not only is the illustration ludicrous as conceded by Dr. Tendai, it is contrary to the plain and ordinary meaning of the term "occasion." The occasion would not be each failure to diagnose, but each event, each time, each date, each opportunity during which the physician committed a breach of the applicable standard of care.

Dr. Tendai offers no case law to directly support his position that repeated negligence could not be found here as a matter of law. In fact, the one case that appears to come closest to contemplating this issue, *Dorman v. Board of Registration for the Healing Arts*, 62 S.W. 3d. 446 (Mo.App. W.D. 2001), supports the Board's position. In the *Dorman* case, a

physician was disciplined based on his failure to properly treat a patient over approximately a one-month period. The patient was having heart trouble and eventually was diagnosed as having suffered an acute myocardial infarction, which ultimately led to his death. The Western District approved, *sub silentio*, the AHC's finding of repeated negligence in the treatment of one patient during several visits over a period from December 9 to December 24. 62 S.W.3d at 451-52.

The basic thrust of the Healing Arts Practice Act is that one act of negligence on one occasion is not a basis for discipline. The Legislature has proceeded on the common sense understanding that even the most conscientious physician can make a mistake. Thus, "repeated negligence" or "gross negligence" is necessary to justify disciplinary action by the Board. The Board would submit that this case illustrates the proper operation of the statute. Had Dr. Tendai but one instance of simple negligence in his care of patient S.G., disciplinary action would not have been appropriate. However, Dr. Tendai repeatedly examined patient S.G., repeatedly discovered that the fetus had not grown, and repeatedly did nothing about it. This course of conduct occurred over a period of 26 days before the baby finally died in the womb. Dr. Tendai had multiple opportunities to do the right thing but on no occasion did he do so. Dr. Tendai was repeatedly negligent over a period of almost a month. The Commission had an adequate basis for its finding of "repeated negligence" on Count III.

**(Appellant's Point) (E) The "overwhelming" evidence that Dr. Tendai gave patient S.G. the proper advice**

**(1) <u>The "Overwhelming" Evidence is basically that Dr. Tendai said he didn't do it a whole bunch of different times</u>**

Dr. Tendai repeatedly refers to the "overwhelming" evidence that he gave patient S.G. all the appropriate advice about IUGR. Dr. Tendai proceeds as though saying "overwhelming" enough times will make it so. In point of fact, the evidence of record for Dr. Tendai's story is far from overwhelming. The only evidence supporting Dr. Tendai's claims of giving the appropriate advice about IUGR and patient S.G.'s supposed non-compliance is Dr. Tendai's own personal testimony. The patient "flow chart" made during the course of treatment does not document any such advice or any such patient non-compliance. No nurse or staff member confirmed Dr. Tendai's testimony. Patient S.G. adamantly denied that Dr. Tendai's version of events was true. In addition, Dr. Tendai told Board Investigator Hutchings a completely different story. Only the aforementioned "sticky notes" purported to confirm any part of Dr. Tendai's story. As noted above, the Administrative Hearing Commission gave the "sticky notes" no credence whatsoever. Dr. Tendai's own expert witness, Dr. Griffin, refused to consider the "sticky notes" a part of the patient record. (Testimony of Dr. Griffin, p. 414 of AHC Transcript, L.F. 702, lines 7 to 12). The evidence was not "overwhelming." The evidence in fact made it abundantly clear that Dr. Tendai was not being truthful. This Court simply cannot say that the Commission's findings and conclusions relative to Dr. Tendai's treatment of patient S.G. were not supported by substantial and competent evidence upon the whole record.

**(2) Testimony of Dr. James Johnson--Board Staff Physician Interviewed Respondent and Gave Him Credit for Telling Truth - - Board Staff Physician Not Aware that Patient S.G. Disputing Respondent's Version of Events - - Commission Took Dr. Johnson's Testimony for What It Was Worth**

Dr. Tendai complains that the Board ignored the opinion of Dr. James Johnson, without comment. Dr. Tendai presented the deposition testimony of Dr. James S. Johnson, formerly employed by the Board of Healing Arts as a staff physician reviewing complaints. Dr. Tendai presented Dr. Johnson's deposition and deposition exhibits as Respondent's Exhibit J. Among Dr. Johnson's deposition exhibits was Deposition Exhibit 2 and Deposition Exhibit 4, both of which reflect Dr. Johnson's findings. In the "Medical Staff Opinion," Deposition Exhibit 4, Dr. Johnson stated as follows:

> In my opinion, Dr. Tendai made an attempt to have this patient, [patient S.G.] follow her care with weekly and biweekly visits, but she refused and she also refused a referral to a perinatologist as requested.

(Respondent's Exhibit J, Deposition of Dr. James Johnson, January 12, 1999, Deposition Exhibit 1)(L.F. 1675; 260-61)(L.F. 1675).

It is obvious from the language employed by Dr. Johnson that he accepted Dr. Tendai's statements as to what happened with patient S.G. at face value. Dr. Johnson had been present when Dr. Tendai appeared for his medical staff interview and gave his version of events. (Respondent's Exhibit J, Deposition of Dr. James S. Johnson, page 23, lines 11 to 14)(L.F.

1649-52) As a further matter, Dr. Johnson was not aware of patient S.G.'s version of events and did not know that patient S.G. disputed Dr. Tendai's version of events. (Id. at page 24, lines 3 to 13)(L.F. 1641--51) Dr. Johnson admitted that he essentially gave respondent credit for telling the truth and wrote out his opinion accordingly. **(**Id. at page 23, line 24 to page 24, line 2)(L.F. 1661). However, on later review, Dr. Johnson found nothing in the patient record supporting respondent's statements as to what he supposedly told patient S.G. (Id. at page 26, line 24 to page 27, line 2)(L.F. 1664).

The Medical Staff Opinion is accomplished for the internal use of the Board of Healing Arts. Not having any special legal effect in this case, Dr. Johnson's opinion stands on its own merits. It is clear that Dr. Johnson heard Dr. Tendai's side of the case and gave him credit for telling the truth. Dr. Johnson did not have the benefit of having patient S.G.'s input. The Commission simply took Dr. Johnson's testimony for what it was worth.

The Board would suggest that Dr. Johnson's Medical Staff Opinion would have the same legal status as a traffic court's verdict on a municipal charge as to who caused a traffic accident or whether negligence was involved. *Cf.*, *Howard v. Riley*, 409 S.W.2d 154 ((Mo. 1966)(fact of conviction not admissible unless upon guilty plea); *Ferguson v. Boyd*, 448 S.W.2d 901 (Mo. 1970). The municipal court's verdict in a traffic accident is considered as not relevant in a civil proceeding. The court views the municipal court's finding as essentially a separate and non-binding opinion of a finder of fact in a separate proceeding. A civil court reserves the right to make its own independent decision as to fault based on the evidence presented. In this case, the Commission must make its own independent decision as to what

happened. While Dr. Johnson chose to accept Dr. Tendai's version of events, this Commission is not required to do so and, in light of the record, should not do so.

As in the case of the issuance of a traffic ticket by a policeman or the finding of guilty in a traffic court, Dr. Johnson's review and opinion would merely constitute the independent opinion of another fact finder on the issue herein under consideration by the Commission. Dr. Johnson's opinion is not binding on the Board or the Commission. Dr. Johnson clearly gave respondent the benefit of the doubt on credibility issues and was not even aware that patient S.G. was disputing respondent's version of events. The Commission clearly took Dr. Johnson's opinion for what it was worth–his personal opinion of what happened based only on talking with Dr. Tendai. The Commission was free to reject Dr. Johnson's opinion on the facts and reach its own.

**III. THE BOARD OF REGISTRATION FOR THE HEALING ARTS DID NOT ERR IN IMPOSING DISCIPLINE ON DR. TENDAI'S LICENSE AS A RESULT OF THE COMMISSION'S FINDINGS OF "INCOMPETENCY," "GROSS NEGLIGENCE," "REPEATED NEGLIGENCE," AND CONDUCT DANGEROUS TO THE HEALTH OF A PATIENT, WHICH FINDINGS AND CONCLUSIONS INCLUDED THE FINDING THAT DR. TENDAI PRESENTED FALSE EVIDENCE TO THE COMMISSION IN ORDER TO ESTABLISH A DEFENSE IN THE FORM OF THE "STICKY NOTES" WHICH THE COMMISSION FOUND TO HAVE BEEN MADE AND ADDED TO THE PATIENT FILE AFTER THE FACT.**

**Standard of Review**

The Board hereby incorporates the Standard of Review as set forth in Point 1, above.

**(1) <u>The Board Prohibits Dr. Tendai from Practicing Obstetrics</u>**

Dr. Tendai complains in his brief that the Board issued its Disciplinary Order and included a provision therein prohibiting him from practicing Obstetrics. The record indicates that a part of Dr. Tendai's pitch to the Board for minimal discipline was his testimony that he was no longer practicing Obstetrics, had not been practicing Obstetrics for some three-and-one-half years, and wanted to henceforth limit his practice to Gynecology. (L.F. 01155; Transcript, Board Disciplinary Hearing, page 34). Based on this testimony, the Board merely formalized the limitation of Dr. Tendai's practice to Gynecology. Counsel described Dr. Tendai's elimination of his obstetrics practice as the result of a "long-standing plan." (L.F. 01189) Dr. Tendai and his counsel essentially invited the Board to include this provision in the Board's Disciplinary Order.

Looked at another way, if Dr. Tendai did not intend to practice Obstetrics in the future, as he testified before the Board, then he has not been harmed by the Board's Disciplinary Order prohibiting him from doing so. Any error in this regard would be harmless error.

**(2) <u>Other Board Disciplinary Orders</u>**

Dr. Tendai goes to great lengths to set out numerous other disciplinary cases generated by the Board during the past few years. Dr. Tendai contends that his discipline was more burdensome than that of many of the other licensees disciplined by the Board in the past few years and that this violated his equal protection rights under the 14th Amendment to the

Constitution of the United States. "However, when the treatment at issue does not involve a fundamental right or a suspect classification, it survives an equal protection challenge so long as it bears a rational relationship to a legitimate government interest. *Artman v. State Bd. of Registration*, 918 S.W.2d 247, 252 (Mo. en banc. 1996).

The Circuit Court of Cole County correctly disposed of the equal protection argument. (Findings of Fact, Conclusions of Law and Judgment, June 1, 2004)(Appendix 3 to Appellant's Brief). The Court carefully considered each of the separate disciplinary cases presented by Dr. Tendai and found that, in each case, the facts were distinguishable from Dr. Tendai's case. (Id.) In order to prevail on an equal protection claim, Dr. Tendai had to demonstrate that he was intentionally treated differently from other similarly situated and that there was no rational basis for the difference in treatment. *Village of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000). It is not enough that Dr. Tendai show that he was treated differently or more harshly than another licensee. *Board of Registration for the Healing Arts v. Brown*, 121 S.W.3d 234 (Mo. banc 2003).

One factor which Dr. Tendai does not take into account is the Commission's finding that Dr. Tendai tendered the fraudulent "sticky notes" as evidence in a Board proceeding, both in the AHC and before the Board. As noted above, the AHC specifically found that the "sticky notes" appeared to have been made up after the fact and did not reflect the true course of events in patient S.G.'s care. (AHC, Findings of Fact and Conclusions of Law, p. 7, ftnt. 4)( L.F. 279). The mendacity of a litigant is traditionally a relevant factor to be considered by the court. The Board certainly had a right to consider findings by the AHC to the effect that Dr. Tendai lied

under oath and made up phony evidence in his efforts to blame the death of her baby on this young, naive girl.[4] The presence of mendacity alone would justify any ostensible difference in discipline between Dr. Tendai's case and the cited cases involving other physicians.

Certainly the integrity, or lack thereof,demonstrated by a physician in the course of a license disciplinary action is a reasonable factor for the Board to take into account in fashioning the appropriate discipline. Integrity would seem to be an important characteristic in the medical profession. There was no showing in the record that the other physicians disciplined by the Board prior to Dr. Tendai's disciplinary hearing lied to the Board, made up phony evidence, and/or testified falsely under oath in the AHC, as Dr. Tendai was found by the AHC to have done.

In addition, the AHC did not just simply find Dr. Tendai negligent in his care of patient S.G. The Commission held that Dr. Tendai was grossly negligent, repeatedly negligent, and acted with incompetence and in a way which was harmful to the health of a patient. The Commission concluded that Dr. Tendai effectively ignored patient S.G.'s condition of IUGR,

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[4] *See, e.g., In re Estate of Latimer,* 913 S.W.2d 51, 57 (Mo. App. W.D. 1995), where the Court quoted the trial court's factual findings: "Defendant was aware of its own mendacity in trying to claim that it had no policy of recalling employees when it clearly did. That mendacity, and Defendant's attempt to cover up its actions, evidences indifference to the rights of Plaintiff and an evil motive." To the same effect is *Conway v. Mo. Com'n on Human Rights,* 7 S.W.3d 571, 575 (Mo. App. E.D. 1999).

a treatable condition, and permitted her baby to die *in utero*. The Commission made the specific finding that "[w]ith proper care, S.G.'s baby would have been born alive." (AHC, Findings of Fact and Conclusions of Law, p. 9, finding No. 40)( L.F. 281). The Circuit Court distinguished the various other disciplinary cases on the ground that such cases did not involve findings of gross negligence, repeated negligence, incompetence, and conduct harming the patient. (Appendix 3, p. A-31 to A-39). In addition, as an additional distinction, the Circuit Court noted the AHC's finding that, with proper care, S.G.'s baby would have been born alive. (Id.) The Circuit Court found each and every case presented by Dr. Tendai to be distinguishable. (Id.)

The Commission quoted the Board's expert witness, Dr. Cameron, who testified that: "This baby didn't have to die. This was a preventable death." (*Id*. at L.F. 290). The Commission concluded that "Tendai's omissions in the treatment of S.G. constitute a gross deviation from the standard of care and demonstrate a conscious indifference to professional duty." (Id.) It is a fortunate thing indeed that the Board is rarely presented with findings by the AHC of this level of negligence on the part of a licensee.

In addition to the several distinctions noted by the Circuit Court, Dr. Tendai's conduct in the present case is distinguishable from that of other disciplinary cases based on his extreme degree of negligence, based on the Commission's findings that he made up phony evidence in the form of the "sticky notes," and based on the Commission's necessarily implied finding that he lied under oath about the circumstances surrounding the treatment of patient S.G. and the creation of the "sticky notes." Findings related to the licensee's mendacity made by the AHC

are legitimate considerations for the Board to take into account in fashioning a licensee's specific discipline. The presence of mendacity findings by the AHC alone makes Dr. Tendai's case distinguishable from the other license disciplinary cases cited by counsel, most of which are settlement agreements between the Board and the licensee.

In addition, it is established law that the Board has considerable discretion in fashioning appropriate discipline in a particular licensing disciplinary case. *Board of Registration for the Healing Arts v. Brown*, 121 S.W.3d 234 (Mo. banc 2003). So long as the Board's discipline is within the statutory limitations, there is no due process limitation. (Id.) Here the Board had a legitimate governmental interest in disciplining Dr. Tendai as it did. There is no equal protection violation shown on the record.

It has been held that merely showing that other licensees were disciplined differently does not make out a violation of the equal protection clause without some evidence of an intent by the Board to apply the law differently as to the complaining party as against others similarly situated. *Board of Registration for the Healing Arts v. Brown*, 121 S.W.3d 234 (Mo. banc 2003). Dr. Tendai produced no such evidence. Mere proof that others supervised by a board have received lesser "punishment," without more, does not make out a prima facie case of a denial of equal protection. *Burgdorf v. Board of Police Commissioners*, 936 S.W.2d 227, 233-34 (Mo. App. E.D. 1996). As a matter of law, a board does not have to consider other punishments before imposing discipline. *Id.* So long as discipline is within a board's statutory authority, a board has broad authority to impose whatever discipline it finds appropriate. *Id.*

In *Burgdorf*, a police officer was "allowed to present punishment evidence during the hearing, despite there being no requirement that the Board consider other punishments before it imposes discipline." *Id.* at 234. Here, Dr. Tendai was able to present evidence to the Board as to how other licensees had been disciplined for conduct, that in Dr. Tendai's estimation, was similar to his own. However, Dr. Tendai was not able to demonstrate to the Respondent that the Board failed to consider or somehow improperly excluded this evidence.

The Court of Appeals for the Eastern District previously held that the Missouri State Board of Accountancy[5] did not abuse its discretion by imposing a harsher discipline on one licensee than on another. *M.M. v. State Bd. of Accountancy*, 728 S.W.2d 726 (Mo.App. E.D. 1987). There, the licensee appealed an order of the Board of Accountancy revoking his license and presented evidence of other instances where the Board imposed a lesser discipline for conduct that could be construed as more egregious. *Id.*, at 727. The Court of Appeals noted that the "mere fact the harshest penalty was imposed here and not in another case, does not, by itself, prove the Board abused its discretion." *Id.* The Court of Appeals held there was

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[5]The State Board of Accountancy is similar to the State Board of Registration for the Healing Arts in that both Boards are required under Section 621.045, RSMo, to file complaints with the Administrative Hearing Commission, both Boards have several grounds for discipline under Section 334.100 and Section 326.310, respectively, and have similar discretion as to the type of discipline (including public reprimand and suspension) that may be imposed under Section 334.100.4 and Section 326.310.3, respectively.

"competent and substantial evidence" on the record to support the Board of Accountancy's order. *Id*. at 727.

Here, the Board of Registration for the Healing Arts imposed discipline that was clearly within its discretion and its statutory authority. While Dr. Tendai did introduce evidence that the Board, on other occasions, imposed differing penalties; at no time was any evidence introduced that Board, here, acted in an abusive or discriminatory fashion by imposing a public reprimand and a 60-day suspension.

Similarly in *Linton v. Missouri Veterinary Med. Bd.*, 988 S.W.2d 513 (Mo. en banc 1999), a veterinarian challenged the Veterinary Medical Board's three-examination limit and introduced evidence that other states did not have a similar restriction. The Missouri Supreme "The mere fact that most or even all states have adopted less stringent policies as to who may practice veterinary medicine is not evidence that the policy chosen by our General Assembly is not rationally related to promoting quality veterinary services." 998 S.W.2d at 517.

Dr. Tendai had to demonstrate that he was intentionally treated differently from other similarly situated and that there was no rational basis for the difference in treatment. The Circuit Court correctly found that there was no evidence that the Board intended to treat Dr. Tendai differently or more harshly than any other licensee. *Board of Registration for the Healing Arts v. Brown*, 121 S.W.3d 234 (Mo. banc 2003). The Circuit Court found that Dr. Tendai had not demonstrated that he was in fact treated differently than any other licensee in the same or similar circumstances. The Circuit Court found a rational basis for the Board's

disciplinary action. The Circuit Court found no equal protection violation. This Court should affirm the findings and conclusions of the Circuit Court.

**IV. THE BOARD OF HEALING ARTS DID NOT ERR IN ITS ORDER IMPOSING DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE, IN THAT SAID ORDER WAS MADE UPON LAWFUL PROCEDURE, WAS AUTHORIZED BY LAW, WAS NOT ARBITRARY, CAPRICIOUS OR UNREASONABLE, DID NOT INVOLVE AN ABUSE OF DISCRETION, AND WAS SUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD.**

**Standard of Review**

The Board hereby incorporates the Standard of Review as set forth in Point 1, above.

**(1.) Administrative Procedure Act Issues**

Dr. Tendai makes the claim that the Board failed to comply with the procedural and notice requirements of the Administrative Procedure Act, chapter 536, RSMo 1994. Dr. Tendai argues that the Board is required to follow all the requirements under chapter 536, which are clearly applicable to the Administrative Hearing Commission. However, Dr. Tendai fails to acknowledge that the Legislature has specified in Section 621.110, RSMo 1994, the procedure to be followed in a Board disciplinary hearing following up a finding of a basis for license discipline by the Commission. Section 621.110, RSMo 1994, provides in part as follows:

> Within thirty days after receipt of the record of the proceedings before the commission and the findings of fact, conclusions of

> law, and recommendations, if any, of the commission, the agency shall set the matter for hearing upon the issue of appropriate disciplinary action and shall notify the licensee of the time and place of the hearing . . ..

The Board followed the statutory requirements and notified Dr. Tendai of the time and place of the hearing. The Notice of Disciplinary Hearing was hand-delivered and personally served on Dr. Tendai by Board Investigator Bryan K. Hutchings on February 29, 2000. (Notice of Disciplinary Hearing, Supplement to Record on Appeal, page 68). Dr. Tendai in fact attended the hearing, was represented by counsel, and presented testimony and evidence on his own behalf.

The Administrative Hearing Commission entered its Findings of Fact and Conclusions of Law on September 2, 1999. Because the Administrative Hearing Commission found that there was cause to discipline Dr. Tendai's medical license under Section 334.100.2(5), RSMo, the Board notified Dr. Tendai that a disciplinary hearing would be held to consider appropriate disciplinary action and specifically of the time and place of the hearing, as required by Section 621.110, RSMo. (Notice of Disciplinary Hearing, Supplement to Record on Appeal, page 65-68). Pursuant to the statutory notice requirement, a disciplinary hearing was held by the Board on April 28, 2000, at 9:00 A.M. at the Lodge of the Four Seasons in Lake Ozark, Missouri. A true copy of the Board's Notice of Disciplinary Hearing dated February 25, 2000, is made an exhibit hereto and incorporated by reference herein as though fully set forth. The Notice of Disciplinary Hearing was personally served on Dr. Tendai by Board Investigator Bryan K.

Hutchings on February 29, 2000. (Notice of Disciplinary Hearing, Supplement to Record on Appeal, page 65-68).

The Board believes itself to be in full and complete compliance with all applicable procedural law and regulations. Specifically, the Board believes that it is in full compliance with Section 334.100, RSMo, governing the filing of disciplinary actions in the Administrative Hearing Commission. As a further matter, the Board believes itself to be in full and complete compliance with the requirements of Section 621.110, RSMo, (Commission's findings and recommendations—hearing by agency on disciplinary action), which governs disciplinary hearings held by the Board after findings of a statutory basis for license discipline against the licensee.

The Board believes that the specific provisions of chapter 334 and chapter 621, RSMO, control and govern the Board's actions, over the general provisions of the Administrative Procedure Act, chapter 536, RSMo. The Board believes that the notice requirements set out in Section 536.067, RSMo, if applicable, were met by the notice provided by the Administrative Hearing Commission at the outset of the Board's action against Dr. Tendai in the Administrative Hearing Commission.

Under the provisions of Section 621.110, RSMo, (Commission's findings and recommendations—hearing by agency on disciplinary action), Dr. Tendai is entitled to notice of the time and place of any disciplinary hearing, which notice has been provided. The specific provisions of Section 621.110 override and supercede any apparent contrary facial requirements of chapter 536.

The Board believes that the specific provisions of chapter 334 and chapter 621, RSMO, control and govern the Board's actions, over the general provisions of the Administrative Procedure Act, chapter 536, RSMo. It is an established rule of statutory interpretation and construction that the specific controls over the general. *Greenbrier Hills Country Club v. Director of Revenue*, 935 S.W.2d 36 (Mo. 1996); *O'Flaherty v. State Tax Com'n of Missouri*, 680 S.W.2d 153 (Mo. 1984).

The Board believes that all of the procedural requirements provided in chapter 536 were in fact complied with by the procedures followed in the Administrative Hearing Commission. The statutes simply set out separate requirements for the procedures to be followed in Board disciplinary hearings. Chapter 621, RSMO. Those procedures were scrupulously followed in Dr. Tendai's disciplinary hearing. The Court should sustain the Board's Disciplinary Order.

**(2) <u>Open Meetings Law issue</u>**

Dr. Tendai claims that the Open Meetings Law, Chapter 610, RSMo, required the Board to deliberate in an open session. Even if Dr. Tendai is correct that the Open Meetings Law, as it existed in April 2000, required the Board to conduct deliberations in a licensing disciplinary hearing in open session, the statute has now been amended to specifically <u>require</u> that licensing boards deliberate in closed session. Section 620.010.14(8), RSMo Supp. 2003, states:

> Any deliberations conducted and votes taken in rendering a final decision after a hearing before an agency assigned to the division

> shall be closed to the parties and the public. Once a final decision is rendered, that decision shall be made available to the parties and the public. (Emphasis supplied).

Therefore, even if Dr. Tendai were technically correct to the effect that the statute in effect in 2000 required deliberations to be conducted in open session, the issue is mooted by the amendment of the statute. A remand in the present case would be a useless act in that a new disciplinary deliberation by the Board would be required to be conducted in closed session pursuant to the terms of the statute. Therefore, if it was error for the Board to deliberate in closed session in 2000, the error was harmless error.

As a further matter, Section 610.027, RSMo, provides that the court on review may invalidate actions taken in violation of the Open Meetings Law, if "the public interest in enforcement of the policy outweighs the public interest in sustaining the validity of the action taken in the closed meeting. . ." Section 610.027.4, RSMo. Since the Legislature ultimately expressed the public policy that the Board deliberations should be conducted in a closed session, the public interest in enforcing a public policy that is no longer public policy (if indeed it ever was) is clearly negligible. This Court should sustain the actions of the Board taken in a closed session.

## Summary and Request for Relief

The Administrative Hearing Commission found multiple grounds for disciplining Dr. Tendai based on substantial and competent evidence. The decision reached by the Commission was in full accordance with Missouri law and procedure and was not arbitrary, capricious or

unreasonable. The Commission did not abuse its discretion. In imposing discipline upon Dr. Tendai's medical license, the Board of Healing Arts followed all rules regarding notice and fair hearing as promulgated by applicable Missouri statutes. The Board's Disciplinary Order was based on substantial and competent evidence. In addition, the Board properly closed its deliberations on Dr. Tendai's case. The Board in doing so did not violate the Missouri Open Meetings Law, §§ 610.010-610.030, RSMo 1994. If in closing its deliberations the Board violated the Open Meetings Law, such violation is at this point moot and constitutes harmless error in light of the legislature's subsequent amendment of the act to require that Board deliberations on discipline be conducted in closed session. Section 620.010.14(8), RSMo Supp. 2003.

This Court should affirm the Findings of Fact and Conclusions of Law of the Administrative Hearing Commission, affirm the disciplinary action of the Board of Healing Arts, affirm the Circuit Court of Cole County, and deny Dr. Tendai's appeal.

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**CERTIFICATE OF SERVICE**

I hereby certify that a two copies of the foregoing and one copy of the disk required by Special Rule No. 1(f) was mailed, postage prepaid, this _____ day of November, 2004, to:

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## 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 contains **21,161** 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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**APPENDIX**