IN THE SUPREME COURT OF MISSOURI

MARK M. TENDAI, M.D.,	)	
	)	
Appellant,	)	
	)	
vs.	)	Case No. SC86110
	)	
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
	)	
Respondent.	)	

Appeal from the Circuit Court of Cole County,
Nineteenth Judicial Circuit, Division I
Case No. 00CV323854
The Honorable Thomas J. Brown, III

BRIEF OF APPELLANT MARK M. TENDAI, M.D.

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

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JURISDICTIONAL STATEMENT

In this appeal, Dr. Tendai is challenging, *inter alia*, the constitutional validity of Section 334.100.2, subsections (5) and (25),[1] and the application of Section 334.100.2(5) by the Missouri Administrative Hearing Commission ("Commission") and the Missouri State Board of Registration for the Healing Arts ("Board") in administrative proceedings which resulted in discipline being imposed upon Dr. Tendai's medical license. Dr. Tendai asserts that the terms "incompetency", "gross negligence", and conduct "which is or might be harmful" to a patient, as used in Section 334.100.2(5) and applied by the Commission and the Board, are unconstitutionally vague and therefore deny Dr. Tendai his right to procedural due process. Dr. Tendai further asserts that the Board's disciplinary order violates his right to equal protection because his license was subjected to discipline far more severe than the discipline imposed on other similarly situated physicians appearing before the Board, and because the discipline imposed upon him was not rationally related to the Board's interest in protecting the public. Dr. Tendai further asserts that Section 334.100.2, subsections (5) and (25), violate equal protection because they create, without justification, differing classifications of physicians suspected of incompetence and establish different procedural rights based on the classification. Dr. Tendai further challenges the June 1, 2004 Judgment of the Circuit Court which affirmed these decisions in their entirety, and which misapplied the standards for determining whether the Board's disciplinary decision violated Dr. Tendai's equal protection rights.

[1] Unless otherwise indicated, all statutory references shall be to RSMo. 2000.

Therefore, because this appeal involves challenges to the constitutional validity of Section 334.100.2(5) and (25), RSMo., the Supreme Court has exclusive appellate jurisdiction of these challenges pursuant to Mo. Const. art. V, §3.

INTRODUCTION

The Missouri State Board of Registration for the Healing Arts ("Board of Healing Arts" or "Board") filed its First Amended Complaint against Mark M. Tendai, M.D. ("Dr. Tendai"), a Board certified OB/GYN with thirty-four (34) years of experience as a physician and over twenty-seven (27) years of experience in obstetrics and gynecology, before the Administrative Hearing Commission ("Commission") on August 19, 1997, concerning Dr. Tendai's care and treatment of two (2) patients in 1992 and 1993. L.F. 00013-19. The Commission conducted a hearing and, thereafter, rendered its Findings of Fact and Conclusions of Law (the "Commission Decision") (Appendix 1) on September 2, 1999, finding in Dr. Tendai's favor on most issues, but against him on some. L.F. 01034-55. The Commissions' Decision found cause to discipline Dr. Tendai concerning his care and treatment of one patient. *Id*. Thereafter, the Board conducted a disciplinary hearing on April 28, 2000, and issued its "Findings of Fact, Conclusions of Law and Order," on May 15, 2000 (the "Disciplinary Order") (Appendix 2). L.F. 01935-39. Therein, the Board ordered that Dr. Tendai's license be publicly reprimanded, and placed on suspension for a period of sixty (60) days. *Id*. In addition, the Board permanently restricted Dr. Tendai from ever practicing obstetrics or obstetrical procedures in the State of Missouri and directed him to attend a medical documentation course. *Id.* The Commission Decision and the Disciplinary Order are collectively referred to as the "Decisions."

Dr. Tendai filed his Petition for Judicial Review Pursuant to Section 536.100 and for Stay Order Pursuant to Section 536.120 in the Circuit Court of Cole County, Missouri, on May 15, 2000, requesting the Circuit Court to reverse the Decisions. L.F. 01940. In addition, Dr. Tendai sought, and the Circuit Court entered, an Ex Parte Stay Order. On May 29, 2001, the Circuit Court entered its Order and Judgment on Petition for Review Under Chapter 536.100, RSMo ("Order & Judgment"), affirming, in its entirety, the Commission's Decision, and reversing in part and remanding in part the Disciplinary Order. L.F. 01983. On June 21, 2001, Dr. Tendai filed a Motion to Modify the Order & Judgment and a Motion for Supplemental Order Staying Enforcement of Disciplinary Order Pursuant to Chapter 536.120, RSMo. L.F. 01988. The Circuit Court issued its Supplemental Order Staying Enforcement of Disciplinary Order Pursuant to Section 536.120, RSMo on June 22, 2001, but denied the Motion to Modify the Order and Judgment on June 29, 2001. L.F. 01994-95.

Dr. Tendai timely 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 obeyance 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) (Appendix 4). When the Circuit Court resumed 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) (Appendix 5). 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") (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 thus appeals the combined Decisions of the Commission and the Board; and, the Judgment, pursuant to Section 621.145, RSMo. 2000.

STATEMENT OF FACTS

Dr. Tendai

Appellant, Mark M. Tendai, M.D. ("Dr. Tendai"), was born in Romania. L.F. 01153[2]. Following World War II, Dr. Tendai moved to the United States of America with his family. L.F. 01153. Dr. Tendai was graduated from high school in Joplin, Missouri and attended St. Louis University. L.F. 01153. He received the degree of Medical Doctor from the University of Missouri-Columbia in 1963, completed a rotating internship from Tulane University in 1964, and completed his OB/GYN residency at the University of Missouri Medical Center in 1972. L.F. p. 00221-223. Prior to his residency, he practiced in a group of six physicians in Kirksville, Missouri, for four and a half years. L.F. 00222. From 1972 through March, 1996, Dr. Tendai conducted a private OB/GYN practice in Springfield, Missouri. After 1996, he practiced gynecology exclusively. L.F. 00223-224. Dr. Tendai became a diplomat with the American Board of Obstetricians and Gynecologists in 1980, and a Fellow of the American College of Obstetricians and Gynecologists in 1982. L.F. 00224-225. Dr. Tendai served eight (8) years in the United States Army Reserve in the field of preventive medicine. L.F. 01154.

[2] References to "L.F.," denote pages within the Legal File. References to "AHC Ex.", "BHA Ex.", or "CC Ex." denote exhibits admitted in proceedings before the Administrative Hearing Commission, the Board of Healing Arts or the Circuit Court, respectively.

He is the father of two (2) children, Mark and Jeanette, having been married to his wife, Janet, since 1964. L.F. 00219.

Board of Healing Arts' Complaints

Dr. Tendai cared for Miss S. G. ("S. G."), an obstetrical patient, in 1992, and Ms. J. W. ("J. W."), another obstetrical patient, in 1992 and 1993. Respondent, State Board of Registration for the Healing Arts ("Board" or "Board of Healing Arts") initially filed a one-count Complaint against Dr. Tendai before the Administrative Hearing Commission ("Commission") on December 13, 1996, concerning his prenatal care and treatment of S.G. L.F. 0001. On August 19, 1997, the Board filed its First Amended Complaint against Dr. Tendai, concerning two patients and containing three counts. L.F. 00013. Count I concerned Dr. Tendai's prenatal care and treatment of S. G. L.F. 00013-16. Count II concerned Dr. Tendai's prenatal care and treatment of J. W. L.F. 00016-18. Count III alleged repeated negligence concerning Dr. Tendai's prenatal care and treatment of both S. G. and J. W.[3] L.F. 00018-19.

[3] Evidence concerning Dr. Tendai's care and treatment of J. W. is not set forth in this Brief because the Commission concluded, in its Findings of Fact and Conclusions of Law (the "Commission Decision"), that Dr. Tendai did not violate any standard of care in J. W.'s treatment and, therefore, there was no cause to discipline Dr. Tendai's license based upon his treatment of J. W.

Commission Hearing

The Commission conducted a three-day hearing on February 8-10, 1999, to determine if there was cause to discipline Dr. Tendai's license. The Board's direct evidence concerning S. G. consisted of S. G.'s deposition, taken on April 2, 1998, L.F. 00574-671; the deposition of the Board's expert, William Cameron, M.D., taken on February 10, 1998, L.F. 00514-573; S. G.'s medical records from 1992, L.F. 00672-739; and, a portion of Dr. Tendai's notes. L.F. 00740-741. The only witness to testify at the hearing for the Board was its investigator, Brian Hutchings, who served as the Board's representative at the hearing and testified only on rebuttal. L.F. 00502-511.

Dr. Tendai offered the testimony of Paula Moore, Dr. Tendai's Office Manager, L.F. 00121-151; the deposition of James S. Johnson, M.D., a board certified OB/GYN hired by the Board of Healing Arts to review cases, including Dr. Tendai's cases, L.F. 00358-392; and, the testimony of William T. Griffin, M.D., a board certified OB/GYN and the Vice Chairman, Professor Emeritus, Department of Obstetrics and Gynecology, University of Missouri School of Medicine. L.F. 00393-502 and L.F. 01015-1033. Dr. Tendai also testified on his behalf and presented his medical records concerning S. G. L.F. 00219-357, 00798-848.

Dr. Tendai's Prenatal Care and Treatment of S. G.

S. G. was born on July 8, 1973. L.F. 00598. She gave birth to her first child, a 7 lb. 9 oz. girl, on May 18, 1989, when she was 15 years old, following a pregnancy of 42 weeks. L.F. 00237, 00801. She experienced no difficulties during her first pregnancy.

L.F. 00610. During April of 1992, S. G. believed that she might be pregnant for a second time. The Women's Community Health Center in Springfield, Missouri, confirmed the pregnancy and provided S. G. with a list of the few obstetricians in the Springfield area, including Dr. Tendai, who would accept Medicaid patients. L.F. 00612-614. S. G. selected Dr. Tendai from that list to provide prenatal care during her second pregnancy. L.F. 00578. During the course of her prenatal care, S. G. visited Dr. Tendai's office on thirteen (13) occasions. L.F. 00802.

S. G. first visited Dr. Tendai's office on April 14, 1992. L.F. 00234-235, 00801-803. At that time, S. G. was a single, eighteen-year old expectant mother who was dependent on Medicaid. L.F. 00801. During that first office visit, Donna Kennedy, Dr. Tendai's nurse, collected S. G.'s vital signs and obtained her preliminary medical history, which were recorded in her medical record. L.F. 00237-238, 00801-802. Then S. G. was escorted to a consultation room to visit with Dr. Tendai, before he conducted her physical examination. L.F. 00237-238. Dr. Tendai visited with S. G., like all of his prenatal patients, concerning general prenatal issues and to answer any questions which she might have had. *Id.* Dr. Tendai performed a physical examination and an ultrasound examination of S. G. during this visit. L.F. 00237, 00801-803. Based upon S. G.'s calculation of inception, and the findings of Dr. Tendai's physical and ultrasound examinations, he concluded that the gestational age of her fetus was approximately seven weeks and her expected due date was November 27, 1992. AHC Ex. D. L.F. 00801-803. Based upon her prior medical history, Dr. Tendai also had S. G. tested for

chlamydia. AHC Ex. D. at L.F. 00801-802. In addition, S. G. received Dr. Tendai's standard bag of prenatal materials before leaving his office on that first visit. L.F. 00238, 00580; AHC Ex. B-Packet Handed Out To Expectant Mothers at L.F. 00798-848. S. G. was scheduled to return to Dr. Tendai's office one month later. L.F. 00802.

On April 17, 1992, Dr. Tendai's office received the results of the chlamydia test. Those results were equivocal. Consequently, S. G. was to be retested on her next visit. L.F. 00802.

S. G. returned for her second visit on May 14, 1992. L.F. 00239, 00802. Her uterus had grown appropriately and her examination was normal. L.F. 00239, 00802.

S. G. saw Dr. Tendai for her third visit on June 15, 1992. Once again, the baby was growing normally and the examination was normal. L.F. 00240-241, 00802.

On June 19, 1992, Dr. Tendai's office called the pharmacy to order a prescription for S. G. and her partner due to her positive chlamydia culture. L.F. 00242. Chlamydia does not present any danger during a pregnancy unless it is a rampant infection or unless it infects the baby during birth. L.F. 00242-243. S. G. was also scheduled for another culture in two weeks. On July 6, 1992, the subsequent culture was negative. L.F. 00243, 00802.

During her visit on July 6, 1992, Dr. Tendai assessed her overall condition as normal. Dr. Tendai was also satisfied with the fetal growth from the prior visit. L.F. 00243, 00802-803.

S. G. returned for her next visit on July 20, 1992. Her vital signs, physical examination and ultrasound examination were all normal. L.F. 00244, 00802-803.

S. G.'s next office visit was on August 20, 1992. Once again, her examinations were routine and she was progressing normally. However, based upon her family history of questionable diabetes, a blood count and blood sugar test were ordered. L.F. 00244, 00802.

S. G. returned for her seventh visit on September 21, 1992. The findings were essentially unremarkable, but Dr. Tendai scheduled her to be rechecked in two weeks, due to her recent weight gain. L.F. 00244-245, 00802.

Dr. Tendai next saw S. G. on October 5, 1992. His overall assessment of her condition on that day was normal. L.F. 00249. However, as she was leaving his office, she made a statement to him in the hall to the effect that "you should be sued for being so strict about weight." L.F. 00245. Dr. Tendai did not write that comment down in the flow sheet in his record. However, he did write it on a "sticky note" or Post-It, and stuck it in the file, because he believed it was a fairly significant change in her personality. L.F. 00245-246. Usually, S. G. said very little during her visits, and this was unusual, so Dr. Tendai decided to make a note to himself in the event that it became a pattern later in this pregnancy or in another pregnancy. L.F. 00246. It was not a note for lawyers. L.F. 00246. Basically, it was just a note to himself that he had to communicate better with the patient. L.F. 00246-247. After writing the note, Dr. Tendai stuck it in the chart, probably behind the patient information sheet. L.F. 00248.

Dr. Tendai's office manager/receptionist, Paula Moore, testified that it was Dr. Tendai's practice to use Post-Its, or sticky notes, to write personal information that he didn't feel was pertinent to their medical information because he didn't want that information floating around the OB room at the hospital when the records were faxed over. L.F. 00129-130. This is a practice which he had developed over the years so that unnecessary offensive information which would not have any bearing upon the well-being of the mother or child would not be sent to labor and delivery and cause the mother undue embarrassment. L.F. 00129-130; 00329-330. Dr. Tendai found the use of sticky notes to be the least offensive manner for noting issues for his future use while keeping the flow sheet clean of potentially embarrassing information. L.F. 00129-130; AHC Ex. I at L.F. 00900..

On October 16, 1992, during S. G.'s next office visit, Dr. Tendai conducted a physical examination, including a pelvic examination and an in-office ultrasound. L.F. 0248; Ex. D. L.F. 00802-803. The results showed that the baby was not growing adequately. L.F. 00249. Concerned that the fetus was not developing properly for its estimated age, Dr. Tendai testified that he discussed his suspicion that the fetus had *intrauterine growth retardation* (IUGR) with S. G. and explained to her the possible consequences of IUGR, including early delivery. L.F. 00249-250. Dr. Tendai also stated that, because of the possibility of IUGR, he advised S. G. to see a perinatologist, but S. G. panicked and refused to follow Dr. Tendai's advice. L.F. 00250-251. Dr. Tendai also testified that he was not sure, on October 16, 1992, whether he had observed a 2-vessel or

a 3- vessel umbilical cord. L.F. 00249 and 00344. The flow chart, which his nurse completed, referred to a 3-vessel cord; however, Dr. Tendai's notes reflect a questionable 2-vessel cord. L.F. 00344 and 00802. Dr. Tendai testified that he explained the possibility of a 2-vessel cord to S. G. on October 16, 1992. L.F. 00250. Following S. G.'s visit, Dr. Tendai wrote a sticky note on October 16, 1992, which stated the following:

> "10-16, almost panics when told of questionable IUGR, questionable two-vessel chord and possibility of early delivery, a need for perinatology consult, refuses same, states feels fine and baby is moving okay. Passive-aggressive tone, warned of fetal danger." L.F. 00250, 00799-800.

Dr. Tendai explained her passive-aggressive behavior, stating that she turned her body away from him while he was talking to her and she would not face him. She would turn her shoulders and shake her head when he was visiting with her. L.F. 00250-251. According to Dr. Tendai, she looked very panicked and scared when he described the procedures that a perinatologist might conduct, including an amniocentesis. L.F. 00250. Dr. Tendai stated that, "she just said she wasn't going to have a needle stuck in her belly." L.F. 00251. S. G. admitted that Dr. Tendai told her, during the October 16, 1992 visit, that the baby was small, but she denied the balance of the conversation. L.F. 00640, line 19. Dr. Tendai scheduled S. G. for a return visit to his office on November 2, 1992. L.F. 00253.

S. G. returned to Dr. Tendai's office on November 2, 1992. L.F. 00253, 802. There was no growth in the fundus between the October 16 and November 2 visits. L.F. 00254, 802. This strengthened Dr. Tendai's belief that S. G.'s baby was suffering from IUGR. L.F. 00254. S. G. testified that Dr. Tendai told her during this office visit on November 2, 1992, that her baby hadn't grown since last month. L.F. 00645-646. She also admitted that Dr. Tendai referred her to Cox Hospital for another ultrasound examination. L.F. 00643-645. Dr. Tendai testified that he also advised S. G. of the need for her to see a perinatologist on that same date. L.F. 00255. S. G. did agree to go to Cox Hospital for another ultrasound and she admitted that she suspected that something was wrong. L.F. 00646-648. S. G. also stated that the ultrasound technician at Cox advised her on November 2, 1992 that her baby only weighed approximately three (3) pounds and that it would be up to Dr. Tendai as to whether he would keep her under his care or whether he would refer her to a specialist. L.F. 00647. The November 2, 1992 ultrasound performed at Dr. Tendai's request at Cox South Hospital confirmed Dr. Tendai's suspicion of IUGR, and also confirmed a "two vessel umbilical cord which may be associated with fetal anomalies." L.F. 00257 and 00806. Dr. Tendai wrote the following on a sticky note on November 2, 1992: "Agrees to Hosp U.S. at least." L.F. 00799-800. Dr. Tendai said that he was pleased that S. G. agreed to have an ultrasound administered at the hospital, even though she would not see a perinatologist. L.F. 00257, 00260-261.

S. G. returned to Dr. Tendai's office for her next scheduled visit on November 9, 1992. L.F. 00263. S. G. admitted that Donna Kennedy (Dr. Tendai's nurse) told her, during that visit, that the results of the Cox ultrasound concluded that she did have IUGR and that Dr. Tendai would explain the situation to her more completely during his examination. L.F. 00649. Dr. Tendai stated that he explained the results of the Cox Hospital ultrasound to S. G. on November 9, 1992, repeated his recommendation to her that she see a perinatologist to care for her and her baby and warned her of the consequences if she failed to do so. L.F. 00264-265. According to Dr. Tendai, S. G. suggested to him that the baby might not be premature because she was now not sure of her last menstrual period. L.F. 00265. Although S. G. admitted that Dr. Tendai's nurse, Donna Kennedy, talked to her about IUGR on November 9, 1992, she denied that Dr. Tendai talked to her about that condition. L.F. 00650. S. G. acknowledged, however, that she did not make any inquiry of Dr. Tendai concerning the lack of growth of her baby or IUGR on November 9, 1992, even though she had been advised on October 16, 1992, November 2, 1992 and November 9, 1992, that her baby was not growing appropriately. L.F. 00650. Following the visit, Dr. Tendai made another notation on a sticky note on November 9, 1992, which stated the following: "States tech at U.S. told her I might send her to a Perinatologist. Told her of need to do so but states now not sure of LMP and still refuses again. Warned her/consequences." L.F. 00799-800.

S. G. returned to Dr. Tendai's office on November 16, 1992 and November 23, 1992. L.F. 00267-268, 00802. S. G.'s baby was not growing. *Id.* According to Dr.

Tendai, he continued to refer S. G. to a perinatologist and warn her of the consequences of her failure to do so on both occasions, L.F. 0267-267; however, she refused his advice. L.F. 00267-269. S. G. denies any referral to a perinatologist, but admitted that she never asked Dr. Tendai about the lack of growth of her baby. L.F. 00651-653.

On November 29, 1992, after feeling no fetal movement for approximately twenty-four (24) hours, S. G. went to Cox South Hospital. L.F. 00270-71. After an ultrasound was administered, S. G. delivered a stillborn child during the morning of November 29, 1992. A necropsy report concluded that the cause of death of S. G.'s stillborn child 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. Umbilical 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. The manner of death is natural." L.F. 00815. According to Dr. Tendai, the baby died as a result of strangulation by a nuchal cord. L.F. 00272.

Dr. Tendai stated that the baby's death could have been prevented if S. G. would have followed his advice and gone to a perinatologist. L.F. 00272. A perinatologist would have performed an amniocentesis and non-stress testing. L.F. 00261. Although Dr. Tendai performed amniocentesis for many years, he, like most of the other obstetricians in Springfield, stopped performing those tests when the perinatologists came

to town. L.F. 00261-262. Furthermore, Dr. Tendai did not have a fetal monitor to perform non-stress testing. L.F. 00262, 00345. Dr. Tendai sent his patients to the hospital for such tests under the supervision of a perinatologist. L.F. 00262.

Dr. Dix was the only perinatologist in Springfield who would accept Medicaid patients. L. F. 00347. Consequently, she was the only perinatologist available for Dr. Tendai's referral of S. G. *Id.* Even though Dr. Tendai was concerned that Dr. Dix might deliver the baby too early, Dr. Tendai insisted that he tried to convince S. G. to see Dr. Dix on numerous occasions. L.F. 00346-347. When S. G. refused the recommendation, Dr. Tendai had few options. L.F. 00263-269, 00346.

Inducing labor or performing a caesarean section were not options. Even on S. G.'s last office visit, November 23, 1992, the position of the baby's head precluded inducement of labor. L.F. 00268. More specifically, the baby's head was ballotable, which meant that the head was down, but not fixed into the pelvis. L.F. 00263, 00268. Consequently, inducing labor was too dangerous to be an option. *Id.*

A caesarean section was not an option without knowing the status of the baby. L.F. 00263-264. An amniocentesis was a prerequisite to performing a caesarean section, because it would show the lung maturity and other important information concerning the status of the baby. L.F. 00264. Since only a perinatologist could perform the amniocentesis and S. G. would not go to see a perinatologist, a caesarean section was not an option.

Under the circumstances, Dr. Tendai believed that the only option available was for S. G. to carry the baby until she went into labor. L.F. 00269, 00346.

Board Investigation

After receiving S. G.'s complaint, the Board assigned the case to one of its investigators, Mr. Brian Hutchings. Mr. Hutchings visited Dr. Tendai's office on April 6, 1993. L.F. 00503. Although Mr. Hutchings claimed that he took written questions with him to the interview and wrote Dr. Tendai's answers down during the interview, he did not offer any such written materials in evidence to support those claims. L.F. 00509. Rather, Mr. Hutchings testified from his memory concerning a conversation that he had with Dr. Tendai nearly six (6) years before the hearing. L.F. 00505-507. According to his recollection, Dr. Tendai did not tell him he had referred S. G. to a perinatologist. L.F. 00507. To the contrary, he claimed that Dr. Tendai told him he had diagnosed the patient with IUGR, but told her that it was best that she carried the baby to term because he was concerned about the lung maturity of the baby and he did not want to refer her to the perinatologist because the perinatologist would probably try to deliver the baby too early. L.F. 00505-506. Mr. Hutchings received a copy of Dr. Tendai's records during his interview on April 6, 1993; however, copies of the sticky notes were not given to him on that date. L.F. 00504-505.

During direct examination of Mr. Hutchings, the Board did not inquire as to whether Dr. Tendai had the file in front of him during Mr. Hutchings' interview or whether

Dr. Tendai reviewed the copies of the records before the information was handed to Mr. Hutchings. L.F. 00502-507. The Board's counsel did not inquire of Mr. Hutchings concerning the follow-up meeting which Dr. Tendai set up when he learned that the sticky notes had not been copied and delivered to Mr. Hutchings. *Id.*

During cross examination, however, Mr. Hutchings admitted that Dr. Tendai told him that the sticky notes had not been copied for the Board and asked his advice as to whether it would be appropriate to take those notes with him when he was interviewed by the Board. L.F. 00509-511. Mr. Hutchings testified that he had always had a good relationship with Dr. Tendai and that he told Dr. Tendai it would be appropriate for him to take those sticky notes to the interview with the Board. *Id.* Mr. Hutchings also admitted that he had completely forgotten about the second meeting until Dr. Tendai discussed the same during his testimony on the previous day. L.F. 00509-510.

Dr. Tendai testified that he recalled the interview with Brian Hutchings, and that he had not reviewed the patient chart before or during his interview with Mr. Hutchings, that his staff made copies of the records for Mr. Hutchings, that he did not review the copies before they were delivered to Mr. Hutchings and that, upon his discovery that the sticky notes had not been copied for the Board, made arrangements to go to Brian Hutchings and discuss the fact with him and to make certain that it would be appropriate for him to take those notes with him when he was interviewed by the Board. L.F. 00273-278, 00348-351. Dr. Tendai had not consulted with an attorney before the interview with Mr. Hutchings, and Dr. Tendai had not even reviewed the patient chart to prepare for that

interview. L.F. 00331-332. He simply sat down with Mr. Hutchings and answered his questions. *Id*.

Ms. Moore, Dr. Tendai's office manager, copied S. G.'s records and gave a copy of those records to Mr. Hutchings when he came to Dr. Tendai's office. L.F. 00127. Inasmuch as the sticky notes were kept in a different area of the chart, either the inside front or the back of the folder, they were not copied or given to Mr. Hutchings when he initially interviewed Dr. Tendai. L.F. 00128. Later, when Dr. Tendai asked her to copy the sticky notes, they were not in the file. Thereafter, she and Donna Kennedy, Dr. Tendai's nurse, located the notes which were stuck on a lab sheet in another patient's chart. L.F. 00128-129. Dr. Tendai did not participate in that search and Ms. Moore had no reason to believe that Dr. Tendai falsified those records. L.F. 00129.

Expert Witnesses

Dr. James S. Johnson, a Board Certified OB/GYN, was hired by the Board in 1990 to serve on its medical staff. L.F. 00907, 931-933. His duties included the review and evaluation of complaints against physicians. L.F. 00909-911, 921-922. As part of his duties for the Board, Dr. Johnson reviewed the medical records in this case and interviewed Dr. Tendai. L.F. 00911-00916, 921, 935-936. Prior to his interview of Dr. Tendai, Dr. Johnson rendered a Medical Staff Opinion, in July of 1993, when he stated the following after reviewing only the medical records:

> "This patient suffered fetal death in utero. There were several conditions including intrauterine growth retardation, a two vessel umbilical cord and

> an increased titre of cytomegalovirus virus. None of these would cause fetal death in utero. The pathology reports a tight nuchal cord as the probable cause of death. *There is no negligence on the part of the doctor in the care of this patient.*"

L.F. 00918 and 934 (See, Appendix 6).

Some time after Mr. Hutchings' meetings with Dr. Tendai and after Dr. Johnson's July 1993 MEDICAL STAFF OPINION, the Board's medical staff, including Dr. Johnson, interviewed Dr. Tendai at the Board's offices in Jefferson City. Dr. Tendai brought his entire file, including the sticky notes, with him. During Dr. Tendai's medical staff interview, he told the Board about his use of sticky notes and offered to send the Board information concerning his use of those notes. L.F. 00333-334, 00350-353. Dr. Tendai signed an affidavit explaining his use of the notes and forwarded same to the Board. L.F. 00352, 00900 (See, Appendix 8). The Board received Dr. Tendai's letter on October 14, 1993. L.F. 00900. Following the medical staff interview, Dr. Johnson prepared a detailed memorandum of the interview and offered the following opinion: "Dr. Tendai made an attempt to have [S. G.] follow her care with weekly and biweekly visits, but she refused and she also refused a referral to a perinatologist as requested." L.F. 00935-937 (See, Appendix 7).

In summary, the Board's medical staff, led by Dr. James Johnson, a Board certified OB/GYN, who reviewed the medical records on two separate occasions and interviewed Dr. Tendai, concluded that: S. G. refused Dr. Tendai's referral to a

perinatologist; and, Dr. Tendai was not negligent. L.F. 00934-937 (See, Appendix 6 & 7).

The Board hired William Cameron, M.D., to testify against Dr. Tendai. Dr. Cameron had previously been hired by the plaintiffs' attorney representing S. G. and J. W. in their malpractice claims against Dr. Tendai. L.F. 00521, 00560. Dr. Cameron is not, and has never been, licensed as a physician and surgeon in the State of Missouri. L.F. 00548. However, he has a limited license to practice in Kansas. L.F. 00549. Since moving to Kansas in 1958, the only hospital privileges that he ever had were those at Belle Memorial Hospital at the Kansas University Medical Center. *Id*. Dr. Cameron's practice moved away from high-risk obstetrics and into infertility issues in the mid to late 1970s. L.F. 00547-548. He is not a perinatologist, and he has been completely out of the practice of obstetrics since July 1, 1988. L.F. 00548. He has never practiced obstetrics outside of the Kansas University Medical Center arena. L.F. 00552.

Four (4) months after the delivery of S. G.'s stillborn baby, she contacted Dr. Cameron by letter which, among other things, stated the following: "Basically I am interested in pursuing a claim against a doctor I had during my last pregnancy." L.F. 00561. After reviewing the information from S. G., Dr. Cameron recommended that she take the case to Attorney Placzek. L.F. 00560.

Dr. Cameron did not attend the Commission's hearing in February of 1999. However, the Board did offer his deposition, which was taken one (1) year earlier on February 10, 1998. L.F. 00514. Although Dr. Cameron had not reviewed the depositions

of Dr. Tendai or S. G., he did opine that referring S. G. to a perinatologist would have been acceptable. L.F. 00563. Dr. Cameron admitted that patients do not always do what you tell them to do and that a physician is not at fault when patients do not do what they are told to do. L.F. 00559-560.

Dr. Tendai requested Dr. William T. Griffin, of the University of Missouri, to review S. G.'s records and make himself available as an expert witness in this case. Dr. Tendai selected Dr. Griffin because Dr. Griffin's reputation is beyond repute, he is a person with impeccable credentials and he is renowned for his painfully honest evaluations. L.F. 00226-227. Dr. Tendai thus selected a person who had taught thousands of physicians how to become obstetricians, a person who had practiced obstetrics and gynecology for thirty-six (36) years, and a person who was not only a Board certified OB/GYN but a person who gave the examinations to persons hoping to become Board certified OB/GYNs. L.F. 00393-401, 01012-1014.

Dr. Griffin explained in detail how he reviewed this file when he presented his notes to the Commission. L.F. 00402-417, 01028-29. According to Dr. Griffin, if Dr. Tendai referred S. G. to a perinatologist, then he did not violate the standard of care. L.F. 00413-414.

Commission Decision

The Commission Decision was rendered on September 2, 1999, finding in Dr. Tendai's favor on most issues, but against him on others. L.F. 01034-55. The Commission Decision found cause to discipline Dr. Tendai's license concerning his care

and treatment of S. G., but not concerning his care and treatment of J. W. *Id*. More specifically, with respect to S. G., the Commission made the following finding:

> "26. Tendai never referred S.G. to a perinatologist, which is a specialist dealing with problems of late pregnancy, because Tendai believed that the perinatologist had a tendency to deliver the babies too early, and he was concerned about the lung maturity of the baby. Tendai therefore decided that the best course of action would be to attempt to carry the baby to term."

L.F. 01039-1040. Although the Commission concluded that Dr. Tendai explained the diagnosis to S. G., it also concluded he violated the standard of care by failing to refer her to a perinatologist. L.F. 01050.

Board of Healing Arts Procedure and Hearing

After receipt of the Commission Decision, the Board issued a "Notice of Disciplinary Hearing" on November 10, 1999, setting the matter for hearing on January 21, 2000, L.F. 01056; and, after granting a request for continuance, issued a subsequent "Notice of Disciplinary Hearing" on February 25, 2000, setting the matter for hearing on April 28, 2000. L.F. 01113. The purpose of the hearing before the Board was to determine the appropriate disciplinary action, if any, to be taken against Dr. Tendai's license following issuance of the Commission's Decision. L.F. 01056, 01113. Dr. Tendai propounded discovery requests to the Board in the form of Requests for Production and Interrogatories, L.F. 01059-01070, 01076-01082; however, the Board

objected to Dr. Tendai's discovery and refused to provide responses thereto. L.F. 01082-01097. Dr. Tendai also filed, on two separate occasions, a "Motion to Dismiss" and an "Objection to Notice" which challenged the sufficiency of the Board's notice and institution of the case under the requirements of Chapter 536, RSMo., but these pleadings were denied by order of the Board. Supp. L.F. 01071-01075; 01113-01117; 01121.

The Board conducted its disciplinary hearing on April 28, 2000. L.F. 01122-01192. The Board's President, and each member individually, affirmed that prior to the hearing each had read the Commission Decision, and each member would particularly consider during their disciplinary deliberations the specific portions of the Commission's record as addressed during the hearing by Dr. Tendai or his counsel. L.F. 01129-01130. Dr. Tendai's counsel renewed his previous motions to dismiss and objections regarding a) the Board's refusal to permit discovery prior to the hearing, b) the sufficiency of the Board's "notices" of hearing and institution of disciplinary proceedings, and c) legal representation and advice to the Board being provided by the Attorney General's office, based upon circumstances suggesting questionable impartiality and objectivity. L.F. 01131-01132. The Board again denied these objections. L.F. 01132.

The Board provided testimony from only one witness. John W. Heidy, the Board's Chief Investigator, testified that Dr. Tendai's license was current and no disciplinary action had ever been taken against his license. L.F. 01138-1139.

Dr. Tendai's testimony before the Board established that during his practice career as an OB/GYN, spanning over thirty years, he had been the subject of only four

malpractice payments on his behalf, two of which arose from his treatment of the patients involved in the underlying Commission case. L.F. 01156-01157. He has been the subject of no other disciplinary or malpractice actions since his treatment of these patients in 1992 and 1993. L.F. 01157. Dr. Tendai continued to accept Medicaid patients in his practice, whom he testified received the same level of care and treatment as his other patients received. L.F. 01156. While not attempting to relitigate issues tried before the Commission, Dr. Tendai explained that he was motivated by ethical concerns to write subjective information about patient demeanor and conduct on "sticky notes", rather than in the patients' actual chart, so that this kind of information would not be "where everybody can see it." L.F. 01157, 01168-01170. In spite of the Board proceeding pending against his license, Dr. Tendai continued to follow this approach, in the interest of protecting the patient's physician-patient privilege. L.F. 01158. He believes "firmly" in protecting this privilege. *Id*. Dr. Tendai also presented the Board with evidence of his excellent professional standing, in the form of five testimonial affidavits, four of which were from professional colleagues. L.F. 01160-01162; 01193-01203.

Finally, Dr. Tendai presented extensive evidence to the Board revealing some eighty (80) previous disciplinary decisions taken by the Board against other physicians, many of which were rendered under facts similar to this case, in which the Board elected to impose only minor discipline or no discipline at all. L.F. 01182-01187; 01244-01935. More specifically, the evidence showed that the Board had previously only reprimanded physicians whose patients had died due to the physicians' omissions, including at least

two previous reprimands to physicians whose conduct had led to stillborn babies. *Id*.; L.F. 01185.

For example, the Board issued a reprimand to Dr. Jeffrey Swetnam on October 15, 1995, when his care was found to be below the acceptable medical standards by administering excessive doses of drugs that depressed the patient's respiration, causing cardiac arrest and the patient's death. L.F. 01470-01479. Additionally, the Board reprimanded Dr. John Denton after it found that he failed to obtain assistance through a critical period of management of a patient which contributed to fetal demise during delivery. L.F. 01578-01583. Similarly, the Board reprimanded Dr. Gary Dausmann on May 28, 1997, when it concluded that his treatment of a pregnant patient was below the acceptable medical standards, resulting in a stillborn birth only one day after the doctor had examined the patient. L.F. 01599-01609. The Board also issued a public reprimand to Andres Apostol on March 8, 1999, based upon his failure to stabilize and treat a patient until surgery could be performed, resulting in the death of that patient. L.F. 01770-01776. Finally, the Board reprimanded Dr. Jessie Cooperider, on July 19, 1999, where the doctor failed to conduct an appropriate screening examination. L.F. 01831-01838. That patient also died. *Id.*

The only evidence before the Board relating to Dr. Tendai's professional and personal reputation was that which Dr. Tendai himself presented. Notably, Dr. Tendai demonstrated, among other things, that he enjoyed a reputation in the community generally and among his professional peers, as being a truthful, trustworthy and caring

person, and a skilled, competent and dedicated physician and surgeon; and, that he carefully and conscientiously attended to the care and treatment of his patients. *See* Affidavits of Drs. Domann, L.F. 01193-01195; Egbert, L.F. 01196-01197; Halverson, L.F. 01198-01199; and, Haen, L.F. 01200-01201; *see also* Affidavit of Joe Huntsman, L.F. 01202-01204. This evidence further revealed that Dr. Tendai was strongly respected by his peers. *Id*. Dr. Haen, in fact, had selected Dr. Tendai to be the gynecologist for Dr. Haen's wife. L.F. 01200-01201.

According to the evidence before the Board, Dr. Tendai enjoyed a strong reputation and had not been the subject of any patient complaints since his treatment of S. G. in 1992 and J. W. in 1992 and 1993. *Id.* There was a total absence of contradictory evidence suggesting that the public interest would in any way be jeopardized by his remaining in practice.

Upon adjournment of the hearing, the Board's President noted that the Board would issue its order "when it's [sic] completed its deliberations and a copy of the order will be mailed to the doctor and his attorney." L.F. 01190. The Board again refused Dr. Tendai's request that the Board's disciplinary deliberations be opened to allow him and his counsel to attend the deliberations, and the Board concluded the public proceedings without reaching a disciplinary determination. L.F. 01190-01191. The Board also denied Dr. Tendai's alternative request, that the Board postpone its deliberations until the resolution of pending appellate cases involving the propriety of closed Board deliberations. *Id.*

Board of Healing Arts Deliberations

Following the public disciplinary hearing, the Board conducted its deliberations and reached its disciplinary determination without further participation or attendance by Dr. Tendai or his counsel. The Board conducted all of its deliberations on April 28, 2000, the same date as the disciplinary hearing. L.F. 01976. During its deliberations, the Board closed the meeting to Dr. Tendai, his attorneys and most of the public. However, the Board allowed eleven (11) to fourteen (14) people, other than its members, to remain in those deliberations. L.F. 01975. Those people included the Board's attorney, Assistant Attorney General Laura Krasser; and, the following employees of the Board: four (4) members of the Board's medical staff; two (2) to five (5) of its investigators; its Executive Director; its paralegal; and, one (1) of its secretaries. *Id.* The record before the Board offers no explanation as to why those persons were allowed to remain in the deliberations, which the Board claimed it was closing, even though Dr. Tendai and his attorney were excluded. The deliberations were not tape recorded or recorded by a court reporter so that a transcript could be prepared. L.F. 01976. In fact, the Board made no record of its deliberations, other than its decision. *Id.*

Board of Healing Arts Disciplinary Order

The Board issued its "Findings of Fact, Conclusions of Law and Order," on May 15, 2000 ("Disciplinary Order"). L.F. 01935. In its "Statement of the Case," which was the introductory portion of the Disciplinary Order, the Board found that a) the Commission had issued its Findings of Fact and Conclusions of Law concluding that Dr.

Tendai's license was subject to discipline, and that the Commission Decision was incorporated within the Board's order; b) the Board had received the Commission's record of proceedings; c) the Board had properly served Dr. Tendai with notice of its disciplinary hearing; d) the Board held a hearing for the purpose of determining appropriate disciplinary action against Dr. Tendai, at which the parties were represented by counsel; e) each Board member certified that he/she had read the AHC order, and that each Board member had attended the disciplinary hearing and participated in the Board's "deliberations, vote and order"; and f) Dr. Tendai is currently licensed by the Board. L.F. 01935-6. The Board's Disciplinary Order did not contain any specific portion or heading thereof identified as "Findings of Fact", despite being so named in the caption of the document. L.F. 01935-01939.

The "Conclusions" portion of the Disciplinary Order stated that: a) the Board has jurisdiction over the disciplinary proceeding, and b) Dr. Tendai's license is subject to disciplinary action by the Board. L.F. 01936-01937. Based thereon, the Board ordered that Dr. Tendai's license be publicly reprimanded, and that his license be suspended for a period of sixty (60) days from the Disciplinary Order's effective date of May 15, 2000. L.F. 01937. Dr. Tendai was also restricted from ever again practicing obstetrics or obstetrical procedures in the state of Missouri, and was required to attend a medical documentation course. L.F. 01937-01938. The Board's Disciplinary Order also provided for additional discipline in the event of future violations by Dr. Tendai. L.F. 01938.

The Board's Disciplinary Order does not describe why the Board selected the discipline that it imposed against Dr. Tendai. Furthermore, the Board's decision offers no explanation as to why its discipline against Dr. Tendai was so much more severe than that which the Board had previously imposed against other physicians in similar circumstances.

The Board's disciplinary order also failed to explain why the Board imposed a sixty day (60) suspension and a permanent restriction against Dr. Tendai's license (which would prohibit him from ever again practicing obstetrics), even though the Board had only reprimanded other physicians under similar circumstances, and the Board failed to explain the basis for its disparate treatment of those physicians. The only suggestion in the record is that offered by the Board's counsel during his closing argument to the Board, that the Board should punish Dr. Tendai. L.F. 01177.

The President of the Board told Dr. Tendai's counsel and the Board's counsel that he and the other members of the Board would read any portions of the transcript from the Commission which were cited to the Board by counsel. L.F. 01129. Dr. Tendai's counsel requested the Board to read Dr. Tendai's testimony; the testimony of Dr. Tendai's expert, Dr. Griffin; and, the cross-examination of S. G. Dr. Tendai's counsel also requested the members of the Board to review its previous decisions in some eighty (80) cases which Dr. Tendai offered into evidence. L.F. 01152, 01178, 01188. The Board offered minimal, if any, discipline against the physicians in these cases, even

wherein cause for discipline had been determined by the Commission. L.F. 01181-01187; HA Exs. 1-B through 1-jj; L.F. 01244-01934.

Circuit Court Proceedings

Dr. Tendai filed his "Petition for Judicial Review Pursuant to Section 536.100 and For Stay Order Pursuant to Section 536.120" before the Circuit Court of Cole County, Missouri, on May 15, 2000. L.F. 01940. On that same date, the Circuit Court issued an Ex Parte Order staying enforcement of the Disciplinary Order. L.F. 01974. By consent of the parties, that order remained in effect, pending further order from the Circuit Court. On June 22, 2001, the Circuit Court issued a Supplemental Order staying the enforcement of the Disciplinary Order. L.F. 01993. The Circuit Court entered its Order and Judgment on May 30, 2001 ("2001 Judgment"). L.F. 01983. Dr. Tendai filed his Motion to Modify the Order and Judgment on May 21, 2001. L.F. 01988. The Circuit Court denied that motion on June 29, 2001. L.F. 01994. Dr. Tendai filed his Notice of Appeal to this Court in the Circuit Court on July 9, 2001. L.F. 01995.

This Court dismissed Dr. Tendai's first appeal for lack of finality because the Board had not yet issued an amended Disciplinary Order in obeyance 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) (See, Appendix 4). When the Circuit Court resumed jurisdiction of the case, the Board of Healing Arts sought a writ of prohibition, arguing that the Circuit Court had no statutory jurisdiction to remand the case back to the Board for findings on the Equal Protection issues. This

Court ultimately decided the writ proceedings, resulting in the December 9, 2003, decision, in Case No. SC85285, which made absolute the writ sought by the Board, but 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) (See, Appendix 5). 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") (*See* 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.

The current appeal, therefore, represents Dr. Tendai's first opportunity to have this Court review the merits of his constitutional and related challenges to the Decisions reached by the Commission and Board; and, the Judgment.

POINTS RELIED ON

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

Authorities Relied On:

U.S. Const. Amend XIV

Perez v. Bd. of Registration for the Healing Arts,

803 S.W.2d 160, 165 (Mo. App. W.D. 1991)

Cocktail Fortune v. Sup'r. of Liquor Control,

994 S.W.2d 955, 957 (Mo. banc 1999)

State v. Helgoth, 691 S.W.2d 281, 283 (Mo. banc 1985)

State ex rel. Nixon v. Telco Directory Publishing,

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

PHYSICIAN'S CONTINUOUS COURSE OF TREATMENT CONCERNING A SINGLE PATIENT; (D) IN THAT THE COMPLAINT BEFORE THE COMMISSION DID NOT ALLEGE THAT DR. TENDAI'S CONDUCT CONCERNING ONLY S. G. CONSTITUTED REPEATED NEGLIGENCE; AND, (E) IN THAT THE COMMISSION FAILED TO CONSIDER EVIDENCE PROPERLY ADMITTED AND ERRONEOUSLY CONCLUDED THAT DR. TENDAI DID NOT REFER S. G. TO A PERINATOLOGIST.

Authorities Relied On:

Duncan v. Bd. for Architects, Professional Eng'rs. And Land Surveyors,

744 S.W.2d 524 (Mo. App. E.D. 1988)

Perez v. Bd. of Registration for the Healing Arts,

803 S.W.2d 160, 165 (Mo. App. W.D. 1991)

Thatcher v. De Tar, 173 S.W.2d 760 (Mo. 1943)

Psychare Management, Inc. v. Dept. of Social Services,

980 S.W.2d 311, 312 (Mo. banc 1998)

III. THE BOARD OF HEALING ARTS ("BOARD") ERRED IN ITS DECISION TO IMPOSE DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE BECAUSE SUCH ORDER VIOLATES DR. TENDAI'S RIGHTS TO EQUAL PROTECTION AND BECAUSE SECTIONS 334.100.2 (5) AND 334.100.2(25) ARE UNCONSTITUTIONAL UNDER THE EQUAL PROTECTION

CLAUSE, IN THAT DR. TENDAI RECEIVED DISCIPLINE FAR MORE SEVERE THAN OTHER PHYSICIANS ENGAGING IN SIMILAR OR MORE SERIOUS CONDUCT, IN THAT THE BOARD'S DISCIPLINE WAS NOT RATIONALLY RELATED TO ITS OBJECTIVE OF PROTECTING THE PUBLIC, AND IN THAT SECTIONS 334.100.2(5) AND 334.100.2(25) CREATE DIFFERING CLASSIFICATION OF PHYSICIANS SUSPECTED OF INCOMPETENCE AND ESTABLISH DIFFERENT PROCEDURAL RIGHTS BASED ON THIS CLASSIFICATION.

Authorities Relied On:

Allegheny Pittsburgh Coal Co. v. Commission of Webster City,

488 U.S. 336 (1989)

Artman v. State Bd. of Registration for the Healing Arts,

918 S.W.2d 247, 252 (Mo. banc 1996)

Village of Willowbrook v. Olech,

528 U.S. 562 (2000)

IV. THE CIRCUIT COURT ERRED IN ITS JUDGMENT DENYING DR. TENDAI'S CLAIM THAT THE BOARD'S DISCIPLINARY ORDER VIOLATED DR. TENDAI'S RIGHTS TO EQUAL PROTECTION BECAUSE THE JUDGMENT WAS UNAUTHORIZED BY LAW; WAS ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVED AN ABUSE OF

DISCRETION; AND, WAS UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD, IN THAT THE BOARD'S DISCIPLINARY ORDER INTENTIONALLY IMPOSED DISPARATE DISCIPLINE AGAINST DR. TENDAI WHICH WAS FAR MORE HARSH THAN THE DISCIPLINE THAT THE BOARD IMPOSED ON SIMILARLY SITUATED PHYSICIANS WITH NO RATIONAL BASIS FOR THE DISPARATE TREATMENT.

V. THE BOARD ERRED IN ITS ORDER IMPOSING DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE BECAUSE THE ORDER WAS MADE UPON UNLAWFUL PROCEDURE; WAS UNAUTHORIZED BY LAW; WAS ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVED AN ABUSE OF DISCRETION; AND, WAS UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD, IN THAT THE

BOARD: (A) FAILED TO SET FORTH IN ITS FINDINGS AND CONCLUSIONS ANY BASIS FOR ITS DISCIPLINARY ORDER; (B) FAILED TO FOLLOW ITS ANNOUNCED PROCEDURE; (C) ORDERED DISCIPLINE UPON DR. TENDAI'S LICENSE IN THE ABSENCE OF COMPETENT AND SUBSTANTIAL SUPPORTING EVIDENCE; (D) ACTED UNLAWFULLY IN CLOSING ITS DISCIPLINARY DELIBERATIONS; (E) FAILED TO ALLOW DR. TENDAI TO DEMONSTRATE HIS COMPETENCY PURSUANT TO STATUTORY PROCEDURE; AND, (F) FAILED TO OBSERVE STATUTORY PROCEDURAL REQUIREMENTS.

Authorities Relied On:

Boyd v. State Board of Registration for the Healing Arts,

916 S.W.2d 311 (Mo.App.E.D. 1995)

Gard v. State Board of Registration for the Healing Arts,

747 S.W.2d 726, 728 (Mo.App.W.D. 1988)

Heinen v. Police Personnel Bd. of Jefferson City,

976 S.W.2d 534, 539 (Mo. App. W.D. 1998)

Mineweld, Inc., v. Board of Boiler and Pressure Vessel Rules,

868 S.W.2d 232, 234 (Mo. App. W.D. 1994)

POINT I

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

STANDARD OF REVIEW

Dr. Tendai appeals from the decision of the Circuit Court of Cole County, which was issued following judicial review proceedings pursuant to §536.100, RSMo. This Court on appeal reviews the underlying decisions of the administrative agencies, and not the decision of the Circuit Court from which this appeal is taken. *Wright v. Missouri Dept. of Social Services*, 25 S.W.3d 525, 527 (Mo. App. W.D. 2000); *Americare Systems, Inc. v. Missouri Dept. of Social Services*, 808 S.W.2d 417, 419 (Mo. App. W.D. 1991). For purposes of this appeal, the orders of the Commission and Board are combined and

treated as one decision, and this Court may review either the decision of the Commission or the decision of the Board. *See State Bd. of Registration for the Healing Arts v. Masters*, 512 S.W.2d 150, 159 (Mo. App. 1974); *see also* §621.145, RSMo.

Pursuant to §536.140, RSMo., this Court may determine whether the underlying agency decisions are:

1) in violation of constitutional provisions;

2) in excess of the statutory authority or jurisdiction of the agencies;

3) unsupported by competent and substantial evidence upon the whole record;

4) unauthorized by law;

5) made upon unlawful procedure or without a fair trial;

6) arbitrary, capricious, or unreasonable;

7) an abuse of discretion.

See Section 536.140.2, RSMo.

In the appeal presented, this Court reviews the administrative decision to determine "whether competent and substantial evidence upon the whole record supports the decision, whether the decision is arbitrary, capricious, or unreasonable, and whether the commission abused its discretion." *See Psychare Management, Inc. v. Dept. of Social Services*, 980 S.W.2d 311, 312 (Mo. banc 1998); *see also EBG Health Care III, Inc. v. Missouri Health Facilities Review Committee,* 12 S.W.3d 354, 358 (Mo. App. W.D. 2000). In reviewing an agency decision, a court must generally defer to the agency's findings of fact. *See State ex rel. Drury Displays, Inc. v. City of Olivette*, 976 S.W. 2d

634 at 635 (Mo. App. E.D. 1998). However, an administrative agency's decision based on its interpretation of law is a matter for the independent judgment of a reviewing court. *Seger v. Downey*, 969 S.W.2d 298, 299 (Mo. App. E.D. 1998). Questions of law determined by the Administrative Hearing Commission are subject to de novo review. *Concord Pub. House, Inc. v. Director of Revenue*, 916 S.W. 2d 186, 189 (Mo. banc 1996). Therefore, this Court may exercise its independent judgment in reviewing the Commission's decisions on questions of law. *See Psychare Management, Inc.*, 980 S.W.2d at 312.

On review of the agency's interpretations of law, the reviewing court must exercise unrestricted, independent judgment and correct erroneous legal interpretations. *Burlington Northern R.R. v. Director of Revenue*, 785 S.W.2d 272, 273-74 (Mo. banc 1990). In addition, where the agency determination under review does not involve agency discretion, but only the agency's application of law to the facts, this Court may weigh the evidence for itself and determine the facts accordingly. *Drey v. State Tax Comm'n.*, 323 S.W.2d 719, 722 (Mo. 1959); *see also State ex rel. Clatt v. Erickson*, 859 S.W.2d 239, 241 (Mo. App. E.D. 1993).

ARGUMENT

Section 334.100.2(5) Is Unconstitutional In That It Violates Plaintiff's Right To Procedural Due Process

The Commission determined that Dr. Tendai violated his professional standard of care, and acted with gross negligence, repeated negligence, and incompetence, and that

he engaged in conduct harmful to a patient with respect to S. G., in violation of §334.100.2(5), RSMo. Supp. 1992. L.F. 00149-52, 01054-55. That statute provides that discipline may lie against a Missouri physician for:

> **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.**

Section 334.100.2(5), RSMo. Supp. 1992 (emphasis added). The terms "incompetency," "gross negligence," and the phrase "conduct or practice which is or might be harmful. . ." are not defined within this provision chapter 334. Furthermore, even though the term "repeated negligence" is defined, its definition is so vague as to render it meaningless. Despite their lack of definition, the Board argued that Dr. Tendai's conduct violated these standards with respect to S. G. in several respects.[4] Following review of the evidence,

[4] Specifically, the Board argued that Dr. Tendai, in violation of the recognized standard of care and in violation of §334.100.2(5), failed to: take an appropriate course of action after he learned of S. G.'s IUGR condition; place her on bed rest; properly monitor and observe her condition; deliver the baby as soon as the fetal lungs reached maturity; refer her to a perinatologist for her high risk pregnancy; explain his diagnosis to her; and, test for a condition known as "CMV" following her diagnosis with chlamydia. L.F. 01049.

the Commission specifically rejected the Board's arguments that the standard of care required S. G. to be placed on bed rest, and that Dr. Tendai failed to properly explain his diagnosis to her. L.F. 01050. However, the Commission did find that Dr. 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."[5] L.F. 01050. Based upon this finding, the Commission concluded that "Dr. 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," and that therefore Dr. Tendai had acted with "gross negligence." L.F. 01051. The Commission further concluded that Dr. Tendai's conduct, as found above, "demonstrated a general lack of a disposition to use his professional ability; thus, there is cause to discipline his license for incompetence," and finally that his conduct was "harmful to the health of a patient," pursuant to §334.100.2(5). *Id*.

A. §334.100.2(5) is unconstitutionally vague.

By establishing grounds for discipline of a physician's professional license, §334.100.2 seeks to prohibit the conduct described in those grounds. This follows from the premise that such a statute exists for the protection of the public, and is thus remedial rather than penal in nature. *See Perez v. Bd. of Registration for the Healing Arts*, 803

[5] November 2, 1992, is the earliest date which the Board's expert witness, Dr. Cameron, believed that Dr. Tendai would have been warranted in taking further action in response to S. G.'s IUGR condition. L.F. 01050.

S.W.2d 160, 165 (Mo. App. W.D. 1991). As such, "it is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Cocktail Fortune v. Sup'r. of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999) (citation omitted). The "void for vagueness" doctrine is applied to ensure that laws give fair and adequate notice of proscribed conduct, and to protect against arbitrary and discriminatory enforcement. *Id*. In applying this doctrine, the test is whether the language at issue conveys to a person of ordinary intelligence a sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices. *Id*. The doctrine is rooted in the Due Process clause of the Fourteenth Amendment. *State ex rel. Nixon v. Telco Directory Publishing*, 863 S.W.2d 596, 600 (Mo. banc 1993). Principles of due process require that a statute "speak with sufficient specificity and provide sufficient standards to prevent arbitrary and discriminatory enforcement." *State v. Allen*, 905 S.W.2d 874, 877 (Mo. banc 1995) citing *Papachristou v. City of Jacksonville*, 405 U.S. 156, 162 31 L.Ed. 110 (1972).[6]

[6] In *Perez v. Bd. of Registration for the Healing Arts*, 803 S.W.2d 160 (Mo. App. W.D. 1991) (a case involving a challenge to §334.100.2(10) on vagueness grounds), the appellate court held due process to require that a statute prohibiting certain activity to 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. *See* 803 S.W.2d at 165.

Lacking legislative definition within subdivision (5) or elsewhere within subsection 2 of section 334.100, the prohibitory terms "gross negligence," "incompetency," "any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public," and "repeated negligence" (which lacks an adequate definition) fail to satisfy due process standards for specificity. A Missouri physician, of common and ordinary understanding, has no guidelines for determining whether his conduct may be considered grossly negligent or incompetent by the Board so as to conform his practice to that standard. In addition, given the relative lack of judicial definition of these terms, a physician has nowhere to turn for guidance other than through a disciplinary proceeding instituted by the Board.[7] These are not terms of general understanding within the medical profession, but rather are legislatively-

[7] "Gross negligence" has been held to differ from ordinary negligence in *kind*. *Duncan v. Bd. for Architects, Professional Eng'rs. And Land Surveyors*, 744 S.W.2d 524 (Mo. App. E.D. 1988). Gross negligence, in a professional discipline context, implies "an act or course of conduct which demonstrates a conscious indifference to a professional duty," thus injecting a specific mental state into the analysis. *See* 744 S.W.2d at 533. Under the facts of a particular case, one court has implicitly defined "incompetence" as constituting a "lack of disposition to use otherwise sufficient present abilities." *See Forbes v. Missouri Real Estate Comm'n.*, 798 S.W.2d 227, 230 (Mo. App. W.D. 1990). There are apparently no reported opinions defining these terms in the context of professional discipline under Chapter 334, RSMo.

empowered disciplinary provisions which have been enacted without definition or standards by which a physician may understand what conduct is prohibited. The phrase "any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient" is so broad in scope as to be nearly all-encompassing, as nearly any practice in which a physician might conceivably engage could be harmful to a patient, given the proper circumstances. Confounding any understanding to be gleaned from the term "incompetency" as used in §334.100.2 (5) is the fact that this term is also used in §334.100.2(25) (commonly known as the "impaired physician" law) which establishes specific procedures to be used by a physician in *demonstrating* his or her competence. A more detailed discussion of this inconsistency, and the constitutional difficulties it creates, appears below.

Finally, the vagueness of the term "repeated negligence" is actually compounded by the definition provided within §334.100.2(5). "Repeated negligence," for the purposes of subdivision (5), 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 . . . licensee's profession;"

Section 334.100.2(5) (emphasis added). Interpretation of this definition for "repeated negligence" necessarily hinges upon the meaning of the word "occasion" as used in this statute. As will be discussed more thoroughly under Point II, *infra*, any permissible application of Missouri law would preclude "occasion" being interpreted in this context

to include a series of appointments with a *single* patient, but would rather require independent negligent acts committed toward more than one patient. This issue highlights better than any other the vagueness of the term "repeated negligence" and the vagueness of the attempted definition using the phrase "more than one occasion." A physician such as Dr. Tendai is obviously unable to ascertain what conduct he must avoid to prevent him from becoming subject to discipline for "repeated negligence." This critical information cannot be ascertained from the terms provided in the statute as written.[8]

In the absence of adequately defined standards for the application of these terms, this Court must find §334.100.2(5) to be void for vagueness and in violation of the rights of Missouri physicians to enjoy procedural and substantive due process prior to discipline of their licenses. *See Cocktail Fortune*, 994 S.W.2d at 957.

[8] The word "occasion" is generally defined as: "a favorable opportunity or circumstance; a state of affairs that provides a ground or reason; an occurrence or condition that brings something about; a time at which something happens." *See Webster's Collegiate Dictionary* (10th Ed. 1999) at p. 803. Obviously, these definitions are of little help in clarifying the meaning of "occasion" in this context and as used in §334.100.2(5), with regard to whether "repeated negligence" may be found based on a series of appointments concerning a single patient.

B. As applied by the Administrative Hearing Commission and the Board of Healing Arts, §334.100.2(5) violates Plaintiff's rights to procedural due process.

By applying the standards for discipline provided in §334.100.2(5) to find cause for discipline of Dr. Tendai's license, the Commission Decision, upon which is based the Disciplinary Order, denies Dr. Tendai due process of law.

In determining the constitutionality of a vague statute, the statutory language must be examined by applying it to the facts at hand. *Perez*, 803 S.W.2d at 165. In this case, there are two sharply differing versions of the facts concerning Dr. Tendai's referral of S. G. to a perinatologist. The Commission concluded that Dr. Tendai did not refer S. G. to a perinatologist because Dr. Tendai was concerned that the only perinatologist who would accept a Medicaid patient such as S. G. would deliver the baby before its lungs were sufficiently mature to survive. L.F. 01039-40 (Finding 26). Dr. Tendai testified that he was concerned about that perinatologist, however, he insisted that he did refer S. G. to a perinatologist on numerous occasions[9]. When considering the constitutionality of the vague statute facing Dr. Tendai, the Court should consider both of these factual scenarios.

Under the first scenario, we must assume, arguendo, the accuracy of the Commission's finding that Dr. Tendai failed to refer S. G. to a perinatologist due to the fact that he was concerned that the only available perinatologist who would accept that

[9] See pages 21-26 for a detailed discussion of Dr. Tendai's testimony concerning his conversations with S. G. concerning a perinatologist.

patient would deliver the baby before its lungs were sufficiently mature to survive. L.F. 01039-40. Under this scenario, Dr. Tendai would have had no way of knowing that his conduct would constitute gross negligence, incompetence, conduct harmful to his patient or repeated negligence, and would thus lead to discipline of his license. When a perinatology consult was not an option, Dr. Tendai had little choice but to continue to monitor the mother and baby with the resources that he had and hope that the mother would begin labor. L.F. 00269, 00346. Dr. Tendai, like most OB/GYNs in his area, in 1992, did not perform amniocentesis or conduct non-stress testing in his office. L.F. 00261-262, 00345. Those procedures were performed by a perinatologist in the hospital. L.F. 00262. Consequently, assuming arguendo the accuracy of the Commission's finding on the absence of a perinatology referral, then Dr. Tendai would have absolutely no idea that his care of S. G. would constitute a deviation from the standard of care, let alone constitute gross negligence, incompetence, conduct harmful to his patient and repeated negligence, which would lead to discipline of his license based on the unavailability to him of an acceptable referral alternative.

Under the second scenario, Dr. Tendai would have had no way of knowing that his *unsuccessful attempts to refer* S. G. to a perinatologist would constitute gross negligence, incompetence, conduct harmful to his patient or repeated negligence, and would thus lead to discipline of his license. In fact, there is no testimony, expert or otherwise, that would suggest that Dr. Tendai's unsuccessful referral of S. G. to a perinatologist would violate the standard of care and subject Dr. Tendai's license to discipline.

The substantial and competent evidence in support of Dr. Tendai's version of events (i.e. the second scenario) is discussed in detail in Point II, subpart (E) (p.80-86). In view of the substantial evidence suggesting repeated attempts by Dr. Tendai to convince S. G. that she needed to see a perinatologist, it would strain credibility to suggest that he would have any way of knowing that his efforts in this regard, dedicated as they were, could amount to gross negligence or incompetence as determined by the Commission.[10] The Commission concludes that "[b]ecause [S. G.'s] fetus was not

[10] The Commission essentially dismisses Dr. Tendai's testimony on this issue in a footnote to its Findings and Conclusions. At page 7 of its decision (fn.4) (L.F. 01040), the Commission discusses Dr. Tendai's testimony regarding his use of "sticky notes" to document subjective patient observations of a sensitive nature, and dismisses the authenticity of such notes relating to S. G., finding Dr. Tendai's testimony on this issue not to be credible. At least implicitly, the Commission relies on this determination in concluding that Dr. Tendai's license is subject to discipline pursuant to §334.100.2(5), because were the Commission to have found that Dr. Tendai could have <u>discussed</u> IUGR and referral with S. G., without formally noting those discussions (or Dr. Tendai's observations concerning her uncooperative attitude) in her patient chart, there would have been no basis for discipline. This conclusion represents an abuse of discretion, because Dr. Tendai could obviously have had such discussions without noting them in the patient's records. Further, Dr. Tendai's testimony before the Board at its disciplinary

appropriately monitored, no one can determine when the baby could have been delivered." L.F. 01050. However, this conclusion ignores Dr. Tendai's consistent testimony that his attempts to refer the patient for the necessary monitoring were to no avail. Ultimately, despite this overwhelming evidence, Dr. Tendai received discipline as a result of the Commission applying its own standards in determining what conduct would rise to the level of discipline allowed under §334.100.2(5), rather than an objective or legislative definition giving clear guidelines for the proscribed conduct. There were no Board regulations in place, no promulgated policies, no announced standards and no "reasonable notice" of the fact that, in essence, a patient's refusal of appropriate referral instructions could lead to license discipline. Nothing, in short, sufficient to prevent the Commission and the Board from acting in a non-arbitrary, non-discriminatory fashion in enforcing the statute. *See Perez*, 803 S.W.2d at 165. By the imposition of discipline in this manner, Dr. Tendai was afforded no reasonable opportunity to know what conduct was prohibited so that he could have acted accordingly in compliance with those standards. *See State v. Helgoth*, 691 S.W.2d 281, 283 (Mo. banc 1985).

Regarding the Commission's conclusion that Dr. Tendai acted with repeated negligence in violation of §334.100.2(5), Dr. Tendai argues in Point II that there was no evidence of a standard of care for physicians acting under Dr. Tendai's circumstances, i.e. where the only perinatologist available for referral was believed by the attending

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hearing casts additional doubt on the Commission's finding in this regard. *See* related discussion in Points III and V, *infra*.

OB/GYN to deliver IUGR babies too early. Therefore, there was obviously no evidence before the Commission from which it could be determined that Dr. Tendai failed to use "that degree of skill and learning ordinarily used under the same or similar circumstances" by other OB/GYNs. Lacking such evidence, the Commission could not lawfully conclude that Dr. Tendai acted with "repeated negligence," because to do so would require evidence to establish what other doctors would have done under "the same or similar circumstances," pursuant to the very language of §334.100.2(5).[11]

For all of these reasons, Dr. Tendai was denied due process by receiving discipline which was premised upon §334.100.2(5) RSMo. The Commission Decision should, therefore, be reversed.

POINT II

THE COMMISSION ERRED IN ITS DECISION THAT DR. TENDAI'S LICENSE IS SUBJECT TO DISCIPLINE FOR INCOMPETENCY, GROSS NEGLIGENCE, CONDUCT HARMFUL TO A PATIENT, AND REPEATED NEGLIGENCE BECAUSE THOSE LEGAL CONCLUSIONS ARE UNAUTHORIZED BY LAW; ARE ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVE AN ABUSE OF DISCRETION; AND ARE UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE

[11] The issue of the proper standard of care in such circumstances is clearly an issue upon which expert testimony would have been required. *See Perez v. Missouri State Bd. of Reg. for the Healing Arts*, 803 S.W.2d 160, 164 (Mo. App. W.D. 1991).

WHOLE RECORD: (A) IN THAT THE BOARD FAILED TO CARRY ITS BURDEN OF ESTABLISHING A STANDARD OF CARE FOR PHYSICIANS NOT HAVING AVAILABLE TO THEM A MEDICALLY APPROPRIATE REFERRAL ALTERNATIVE; (B) IN THAT THE COMMISSION'S LEGAL CONCLUSION THAT DR. TENDAI IS SUBJECT TO DISCIPLINE FOR NOT REFERRING S. G. TO A PERINATOLOGIST IS ERRONEOUS IN LIGHT OF THE COMMISSION'S FINDING OF FACT THAT DR. TENDAI DID NOT REFER S. G. TO THE ONLY AVAILABLE PERINATOLOGIST WHO WOULD ACCEPT MEDICAID PATIENTS DUE TO DR. TENDAI'S CONCERN THAT THE PERINATOLOGIST WOULD DELIVER THE BABY BEFORE ITS LUNGS WERE SUFFICIENTLY MATURE TO SURVIVE; (C) IN THAT REPEATED NEGLIGENCE CANNOT, UNDER MISSOURI LAW, RESULT FROM A PHYSICIAN'S CONTINUOUS COURSE OF TREATMENT CONCERNING A SINGLE PATIENT; (D) IN THAT THE COMPLAINT BEFORE THE COMMISSION DID NOT ALLEGE THAT DR. TENDAI'S CONDUCT CONCERNING ONLY S. G. CONSTITUTED REPEATED NEGLIGENCE; AND, (E) IN THAT THE COMMISSION FAILED TO CONSIDER EVIDENCE PROPERLY ADMITTED AND ERRONEOUSLY CONCLUDED THAT DR. TENDAI DID NOT REFER S. G. TO A PERINATOLOGIST

STANDARD OF REVIEW

Dr. Tendai hereby incorporates the Standard of Review as set forth in Point I.

ARGUMENT

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

The Commission erroneously found that Dr. Tendai did not refer S. G. to a perinatologist so that her baby could have been appropriately monitored.[12] Based upon that finding, the Commission rendered its flawed legal conclusion that Dr. Tendai's conduct violated the standard of care and, therefore, also violated Section 334.100.2(5), which allows discipline against a physician for the following:

> **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.**

Section 334.100.2(5), RSMo. Supp. 1992 (emphasis added). More specifically, the Commission found that Dr. Tendai's conduct constituted gross negligence, incompetency, repeated negligence and conduct which was harmful to a patient. L.F. 01049-52, 01054-55. Underlying each of these conclusions is the Commission's wholly

[12] Dr. Tendai's argument concerning this erroneous finding by the Commission is set forth below in subpart (E) of this point.

unsubstantiated belief that Dr. Tendai failed to use that degree of skill and learning ordinarily used under the same or similar circumstances by other physicians. L.F. 01050.

The Board bears the burden of proving all elements of its claim against Dr. Tendai, including the standard of care. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo.App.W.D. 1992); *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo.App.W.D. 1989). The standard of care in medical disciplinary cases utilizes the common law definition of negligence such that a physician violates the standard of care if the physician fails to use that degree of skill and learning ordinarily used under the same or similar circumstances by other physicians. *Duncan v. Bd. for Architects, Professional Eng'rs. and Land Surveyors*, 744 S.W.2d 524, 532 (Mo. App. E.D. 1988). The key phrase in the standard of care is **"under the same or similar circumstances."** William Cameron, M.D., presented the Board's testimony on the standard of care. While Dr. Cameron's credibility is subject to challenge, it is not necessary to do so at this point because Dr. Cameron's opinions were not based upon the same or similar circumstances which the Commission found Dr. Tendai encountered.

The Commission found that Dr. Tendai did not refer S. G. to a perinatologist because Dr. Tendai was concerned that the only available perinatologist would attempt to deliver the baby before its lungs were sufficiently mature to survive. L.F. 01039. Dr. Cameron's testimony, given by deposition one year before the hearing, did not take into consideration this critically important fact. L.F. 00514. After reviewing only a portion of the records concerning S. G. (which excluded the only records which revealed Dr.

Tendai's perinatology referrals), Dr. Cameron opined that Dr. Tendai should have referred S. G. to a perinatologist. Dr. Cameron was not, however, advised that Dr. Tendai was concerned that the only available perinatologist would attempt to deliver the baby before its lungs were sufficiently mature to survive. The Board offered no further evidence to establish the standard of care under these circumstances. Consequently, the Board offered no expert testimony to carry its burden to establish the standard of care for physicians under the same or similar circumstances which the Commission found Dr. Tendai confronted. Clearly, this is an issue which would have required expert testimony. *See Perez v. Bd. of Registration for the Healing Arts*, 803 S.W.2d 160, 165 (Mo. App. W.D. 1991).[13]

What was the standard of care for a physician who believed that a perinatology consult was required, but had no perinatologist available with whom he had confidence? The Board didn't present any evidence on this subject because the Board believed, but failed to prove, that Dr. Tendai simply didn't care about S. G. and wanted to let her baby die. Dr. Tendai did not present any evidence on this subject because Dr. Tendai maintained, and continues to maintain, that he did refer S. G. to a perinatologist, even though he was concerned that the perinatologist might deliver the baby before its lungs

[13] *State Bd. of Reg'n. for the Healing Arts v. McDonagh*, 123 S.W.3d 146, 158-59 (Mo. banc 2003), in which this Court remanded the Commission decision finding no cause to discipline where physician's expert failed to testify concerning the precise standard of care on which his opinion was based.

were sufficiently mature to survive. The Commission completely ignored the absence of any expert evidence required to establish the critical standard of care which underlies its entire decision. Inasmuch as the Board bears the burden of proving each element of its case, its failure to present expert testimony, or any testimony, on the standard of care in this case results in the Board's failure to carry its burden of proof. Consequently, the Commission's conclusions that Dr. Tendai's conduct violated the standard of care and that Dr. Tendai's license is subject to discipline are erroneous. The Commission Decision should, therefore, be reversed.

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

A. The decision that Dr. Tendai acted incompetently, with gross negligence, with conduct harmful to a patient and with repeated negligence is unsupported by competent and substantial evidence upon the whole record.

1. "Incompetently"

As previously discussed, Chapter 334, RSMo. contains no definition of "incompetently" as that term is used in §334.100.2(5). Being a remedial statute, this Court must accord the words used in this statute their plain, ordinary and usual meanings. *Bhuket v. State Bd. of Registration for the Healing Arts*, 787 S.W.2d 882, 885 (Mo. App. W.D. 1990). "Incompetency," as defined by the Commission, is "a general lack of present ability or lack of a disposition to use a present ability to perform a given duty." L.F. 01047. *Webster's* defines "incompetent" to mean "lacking the qualities needed for effective action; not legally qualified; inadequate or unsuitable for a particular purpose." *Webster's New Collegiate Dictionary* (1st Ed. 1975).

Under either the Commission's or the dictionary definition, the evidence before the Commission was wholly insufficient to support its conclusion that Dr. Tendai acted incompetently with respect to S. G. As previously noted, the Commission found that Dr. Tendai did not refer S. G. to a perinatologist because Dr. Tendai was concerned that the only available perinatologist would attempt to deliver the baby before its lungs were sufficiently mature to survive. L.F. 01039-40. **Even if we were to assume that this conduct violated the standard of care (which we do not) such a violation would only constitute negligence, not incompetency.**

If Dr. Tendai did not refer S. G. to a perinatologist due to his concern for the baby's well-being, then that conduct would not satisfy the Commission's definition of "a general lack of present ability or lack of a disposition to use a present ability to perform a given duty." Furthermore, that conduct would not satisfy *Webster's* definition, because

that conduct would not demonstrate that Dr. Tendai was "lacking the qualities needed for effective action; not legally qualified; inadequate or unsuitable for a particular purpose." There was no evidence that Dr. Tendai lacked the ability or disposition to perform his duties. The Commission found that Dr. Tendai did not refer S. G. out of his concern about the safety of the practices of the only available perinatologist. L.F. 01039-40. Concern for your patient does not evidence incompetency.

The Commission's decision that Dr. Tendai acted incompetently in violation of §334.100.2(5), RSMo., being a decision based on the Commission's interpretation of that law, is a matter for the independent judgment of this Court in performing its review. *Seger v. Downey*, 969 S.W.2d 298, 299 (Mo. App. E.D. 1998). In view of the overwhelming evidence described above, the Commission's conclusion that Dr. Tendai's conduct was incompetent amounts to an abuse of discretion. The Commission's Findings and Conclusions contain no explanation of why the lack of a referral due to the physician's concern over the absence of a safe referral would constitute incompetency. This Court is clearly entitled to determine whether the Commission could have reasonably reached its conclusion upon consideration of all the evidence before it, and its decision may be reversed if this Court determines that the decision is against the overwhelming weight of the evidence. *Barnes Hosp. v. Missouri Comm'n. on Human Rights*, 661 S.W.2d 534 (Mo. banc 1983).

The Commission's conclusion that Dr. Tendai acted incompetently is a) an abuse of discretion; b) arbitrary, capricious, and unreasonable; and c) unsupported by

competent and substantial evidence upon the whole record, and therefore must be reversed by this Court. *See Psychare Management, Inc. v. Dept. of Social Services*, 980 S.W.2d 311, 312 (Mo. banc 1998).

2. "Gross negligence"

In an administrative case considering professional discipline, gross negligence means "an act or course of conduct which demonstrates a conscious indifference to a professional duty." *Duncan v. Bd. for Architects, Professional Eng'rs. and Land Surveyors*, 744 S.W.2d 524, 533 (Mo. App. E.D. 1988). For the same reasons that the evidence is insufficient to support a conclusion that Dr. Tendai acted incompetently, there clearly is not substantial and competent evidence to support a conclusion that Dr. Tendai acted with "conscious indifference" to S. G.'s condition. Again, the evidence (as described in subpart (E) of this point) is *overwhelmingly* against such a conclusion.

The Commission specifically found that Dr. Tendai did not refer S. G. to the only perinatologist available because Dr. Tendai was concerned that the perinatologist would attempt to deliver the baby too soon. L.F. 01039-40. How can that finding lead one to believe that Dr. Tendai acted with conscious disregard for his patient or with intent to harm his patient?

The Commission's conclusion, therefore, is a) an abuse of discretion; b) arbitrary, capricious, and unreasonable; and c) unsupported by competent and substantial evidence upon the whole record, and therefore must be reversed by this Court. *See Psychare Management, Inc.*

3. "Any conduct which is or might be harmful or dangerous to. . .a patient"

Section 334.100.2(5) also provides a basis for discipline if a physician engages in "any conduct which is or might be harmful or dangerous to the mental or physical health of a patient or the public." The Commission further concluded that Dr. Tendai's conduct toward S. G. was harmful to the health of a patient,[14] in violation of this provision. L.F. 290, 294. S. G.'s baby died because the baby's cord was wrapped around its neck and strangled the baby. L.F. 00272 (See, Appendix 6).

Upon consideration, this Court must reverse this conclusion for a fundamental reason: any harm which befell S. G. or her baby resulted directly from the nuchal cord, not from any act or omission by Dr. Tendai. The overwhelming weight of the evidence again bears this out, and thus the Commission's conclusion otherwise must be reversed for all the reasons set forth above.

(C) REPEATED NEGLIGENCE CANNOT, UNDER MISSOURI LAW, RESULT FROM A PHYSICIAN'S CONTINUOUS COURSE OF TREATMENT CONCERNING A SINGLE PATIENT

The Commission further found cause to discipline Dr. Tendai's license based upon his engaging in "repeated negligence" with respect to S. G. L.F. 01054-55. As expressed by the Commission:

[14] The Commission does not specify whether "a patient" refers to S. G. or her stillborn baby. Presumably, this reference could apply to either without altering the Commission's conclusion.

> "We find repeated negligence in Tendai's treatment of [S. G.]. This patient had visits with Tendai on November 9, November 16, and November 23, 1992, after her November 2, 1992 ultrasound showed IUGR, and her fundus showed no growth on November 2, 9, and 16, and minimal growth on November 23, yet Tendai did not refer her to a perinatologist or conduct testing and deliver the baby. Therefore, we find cause for discipline under section 334.100.2(5) for repeated negligence."

L.F. 01055. The Commission, therefore, concludes that repeated negligence may be found by virtue of acts taken or not taken over a series of appointments *with the same patient.* Although the meaning of "repeated negligence" in this context has apparently not been subjected to definition by appellate review in a Missouri court, the Commission's application of the term defies the provision's self-contained definition and analogous principles found in Missouri common law. As also noted by the Commission, §334.100.2(5) defines "repeated negligence" 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 a member of the applicant's or licensee's profession[.]

(Emphasis added). Other states, in applying similar language, have concluded that in order to find professional discipline warranted for repeated negligence, there must be separate acts of negligence taken against *different* patients or clients.

In an attorney discipline matter, the court in *In re Purvis*, 781 P.2d 850 (Or. 1989), found discipline to lie against an attorney for "repeated negligence" based upon complaints received by several of Purvis' former clients, suggesting that the separate complaints were necessary for this finding. *Id*. Likewise, the Supreme Court of Alaska has held that three counts of negligent conduct brought against a physician, each involving a different patient, can be taken together to satisfy the "repeated negligent conduct" standard for discipline as set forth by Alaska statute; implicit in this holding is that the negligent conduct reflected in each individual count would not, alone, suffice in meeting the "repeated negligent conduct" standard. *See Halter v. Medical Board*, 1999 WL 10000931 (Alaska 1999). Finally, in *Jean-Baptiste v. Sobol*, 209 A.D.2d 823, 619 N.Y.S. 2d 355 (N.Y. App. Div. 1994), the revocation of a physician's license was upheld based upon charges that the doctor had engaged in "negligence on more than one occasion in regard to his treatment of *six* patients." *See* 209 A.D.2d at 824 (emphasis added).

Clearly, other states have taken the position that "repeated negligence," in professional disciplinary matters, requires acts of negligence in the treatment of more than one patient, and not simply serial acts during the same course of treatment for a single patient. Further support for this conclusion comes by virtue of Missouri time limitations law, in the form of the "continuous treatment doctrine."

The continuous treatment doctrine, as a component of Missouri common law, was first expressed in the case of *Thatcher v. De Tar*, 173 S.W.2d 760 (Mo. 1943)

("*Thatcher*") and has been followed in many subsequent opinions.[15] Summarized, *Thatcher* and its progeny hold that the statute of limitations applicable to a medical malpractice action[16] does not commence running *until treatment of the patient has terminated*, where the treatment is of such a nature as to charge the physician with a duty of *continuing care* and treatment essential to recovery. *See* 173 S.W.2d at 762-63. The continuing nature of such treatment has the effect of tolling the statute of limitations until the physician-patient relationship ceases. *See e.g. Weiss v. Rojanasathit*, 975 S.W.2d 113 (Mo. banc 1998). The premise underlying these holdings is that the entire course of treatment is deemed for limitations purposes to be one "act" of negligence, complete when the course of treatment concludes. The logical application of this doctrine by legal analogy to the present case is inescapable. Dr. Tendai's treatment of S. G. was clearly of a continuing nature, and was essential to her and her baby's "recovery"[17]. Thus, by analogy to the well-recognized continuous treatment doctrine, Dr. Tendai's entire course of treatment for S. G. was legally but one "act" for purposes of negligence analysis.

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[15] *See generally* cases cited at *Mo. Digest, Limitation of Actions* §55(6).

[16] Section 516.105, RSMo. provides that such actions shall be brought "within two years from the date of occurrence of the act of neglect complained of," with certain exceptions for minors and for particular acts of neglect.

[17] Prenatal care would appear the very essence of "continuing" treatment, and is necessary for the health and welfare of both mother and baby prior to, during, and after birth of the child.

Thus, the Commission's conclusion that "repeated negligence" may lie in the continuing course of treatment for a single patient is contrary to Missouri law and must therefore be reversed. *See Seger v. Downey*, *supra*.

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

The Commission found cause to discipline Dr. Tendai's license based upon "repeated negligence" in his treatment of S. G., pursuant to §334.100.2(5). Explaining this conclusion, the Commission stated:

> **We find repeated negligence in Tendai's treatment of [S. G.]. This patient had visits with Tendai on November 9, November 16, and November 23, 1992, after her November 2, 1992 ultrasound showed IUGR, and her fundus showed no growth on November 2, 9, and 16, and minimal growth on November 23, yet Tendai did not refer her to a perinatologist or conduct testing and deliver the baby. Therefore, we find cause for discipline under section 334.100.2(5) for repeated negligence.**

L.F. 01055. In addition to incorrectly applying the term "repeated negligence" in a manner inconsistent with analogous Missouri common law and interpretations from the courts of other states (*see* subpart C of this point), the Commission's conclusion must

also be reversed for the fundamental reason that the Board never pleaded that repeated negligence be premised on Dr. Tendai's conduct toward only S. G.

As more fully described in the Statement of Facts[18], the Board's First Amended Complaint against Dr. Tendai contained three counts. L.F. 00013. As described by the Commission, Count I concerned S. G.; Count II concerned J. W.; and, Count III asserted "that the various omissions asserted in Counts I and II constituted repeated negligence." L.F. 01048. Consequently, the Board did not plead that Dr. Tendai's conduct concerning S. G. constituted repeated negligence. Rather, the Board pleaded, in a separate Count III, that Dr. Tendai's conduct concerning S. G. combined with his conduct concerning J. W. constituted repeated negligence. The Commission again acknowledged that repeated negligence was only sought in Count III, in its footnote 6 at page 18 of its Decision. L.F. 01051. The Board offered no evidence that Dr. Tendai's conduct concerning S. G. constituted multiple acts of negligence. Furthermore, the Board did not even suggest in any of its pleadings, Proposed Findings of Fact and Conclusions of Law, or briefs filed before the Commission that Dr. Tendai's conduct concerning only S. G. constituted repeated negligence. Thus, Dr. Tendai had no opportunity, or reason, to defend against the Commission's conclusion that his conduct regarding only S. G. constituted "repeated negligence."

Clearly, the Board only intended, and only pleaded for, a finding of cause for discipline for "repeated negligence" if it were found that Dr. Tendai acted negligently

[18] See page 19 of this Brief.

toward both patients mentioned in Counts I and II. By the pleadings themselves, it would have been necessary to find combined cause for discipline based on his conduct toward both patients prior to concluding that he acted with repeated negligence. By concluding otherwise, the Commission has granted relief not requested by the pleadings, and has accordingly exceeded its authority and abused its discretion. *Ballew v. Ainsworth*, 670 S.W.94, 103 (Mo.App.E.D. 1984), *Duncan v. Bd. for Architects, Professional Eng'rs. and Land Surveyors*, 744 S.W.2d 524, 538-39 (Mo. App. E.D. 1988). This conclusion must, therefore, be reversed.

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

The lynchpin of the Commission's conclusion on this point is its finding that Dr. Tendai failed to refer this patient to a perinatologist after becoming aware that the patient's fetus was experiencing IUGR, or by failing to conduct tests himself and deliver the baby after its lungs reached maturity. L.F. 01050. In order to reach this conclusion, however, the Commission apparently disregards the substantial evidence which reveals: a) that Dr. Tendai was aware of possible IUGR as early as October 16, 1992; b) that during his appointment with the patient on October 16, 1992, Dr. Tendai first discussed possible IUGR with the patient, along with the possibility that a perinatology consult would be required; c) that during his appointment with the patient on November 2, 1992,

Dr. Tendai discussed findings with the patient which increased his concern that IUGR was present, and told the patient that she would need to consult with a perinatologist in order that specific additional testing and monitoring could be done, and that he (Dr. Tendai) was not equipped to perform these services in his office and that the services would need to be provided by a perinatologist; and d) that at each appointment during which the need for these additional services and referral was discussed, and during the course of his treatment generally, the patient grew ever more resistant to these steps and ultimately refused to follow Dr. Tendai's advice.

The evidence is overwhelming that Dr. Tendai attempted, on several different occasions, to refer S. G. to a perinatologist for further monitoring of what was his growing belief that the fetus was suffering from IUGR. In fact, Dr. Tendai testified that during his appointment with her on October 16, 1992, the date on which he first believed that IUGR had developed, he discussed with S. G. the likelihood that she would need to be referred to a perinatologist for consultation regarding that condition, and discussed with her the nature and dangers of IUGR. L.F. 00249-251. However, S. G. reacted with fear to the news of IUGR and resisted Dr. Tendai's suggested referral to a perinatologist. L.F. 00251. Dr. Tendai further testified about the patient's "pattern" of reluctance to pay attention when he was discussing with her the IUGR condition in later appointments. L.F. 00253. His testimony further reveals that S. G. became generally uncooperative as the course of treatment continued and after IUGR was becoming a likely diagnosis. L.F. 00235-236; 00253. During the appointment of November 2, 1992, further examination

strengthened Dr. Tendai's belief that IUGR was present, and he then definitively told S. G. that a perinatology consultation would be necessary, along with a possible amniocentesis. L.F. 00255. His instructions were met with "denial" by S. G. *Id*. Ultimately, Dr. Tendai's testimony as shown above makes clear that he attempted repeatedly to refer S. G. for a perinatology consultation, but that his attempts failed due to the patient's resistance. L.F. 00261. Despite this, Dr. Tendai was successful in obtaining the patient's agreement to an ultrasound examination. *Id*. The need for other tests necessitated by the apparent IUGR, including amniocentesis and "non-stress" testing, were discussed with S. G., and Dr. Tendai made clear that he did not have the facilities to perform these tests himself, that she must see a perinatologist for these procedures. L.F. 00261-263.

This pattern continued through the appointment on November 9, 1992, during which Dr. Tendai warned the patient that fetal death could occur as a result of her IUGR condition, were that condition not properly monitored through an amniocentesis performed by a perinatologist, and that non-stress testing was by this time "two to three times more important" than it would have been a few weeks earlier, when he first recommended it; Dr. Tendai informed the patient that the fetal situation was now "dicy." L.F. 00265-266. These entreaties by Dr. Tendai were met, as usual, with the patient's refusal to comply, even though Dr. Tendai clearly exerted considerable effort to change her mind. L.F. 00266-267.

On November 16 and 23, 1992, Dr. Tendai conducted his final office appointments with S. G. On both of these days, Dr. Tendai repeated his earlier instruction that the patient needed the monitoring that a perinatologist could provide, based on the fact that the patient's fetus had grown only an insignificant amount between appointments. L.F. 00267-270. These efforts were again met with the patient's refusals. *Id*. This was despite the fact that Dr. Tendai even appealed to the patient to consider the welfare of her baby. L.F. 00270. Thereafter, on November 29, 1992, S. G.'s baby was stillborn at Cox Hospital, after reporting to hospital staff that she had felt no fetal movement for the previous twenty-four hours. L.F. 00270-271. S. G. did not call Dr. Tendai's office to report this absence of fetal movement, despite that Dr. Tendai had provided her with specific instructions to call him if she ever felt the baby quit moving for more than a couple of hours. L.F. 00271. At each appointment from October 16 through November 23, 1992, Dr. Tendai recorded fetal heart tones, indicating a viable fetus. L.F. 00272. Dr. Tendai believes that S. G.'s baby could have been saved had she followed his repeated advice, and he denies deviating from the standard of care. *Id*.

The Commission's decision that Dr. Tendai acted incompetently, with gross negligence, or in a manner harmful to a patient, in violation of §334.100.2(5), RSMo., being a decision based on the Commission's interpretation of that law, is a matter for the independent judgment of this Court in performing its review. *Seger v. Downey*, 969 S.W.2d 298, 299 (Mo. App. E.D. 1998). In view of the overwhelming evidence described above, the Commission's conclusion that Dr. Tendai's conduct was

incompetent, grossly negligent, or harmful to a patient, amounts to an abuse of discretion. The Commission's Findings and Conclusions contain no explanation of whether, or upon what basis, the testimony of Dr. Tendai on these critical issues was found not to be credible. Although witness credibility determinations reside with the Commission, this Court is clearly entitled to determine whether the Commission could have reasonably reached its conclusion upon consideration of all the evidence before it, and its decision may be reversed if this Court determines that the decision is against the overwhelming weight of the evidence. *Barnes Hosp. v. Missouri Comm'n. on Human Rights*, 661 S.W.2d 534 (Mo. banc 1983). Finally, the testimony of the Board's own expert, Dr. Cameron, fails to refute the credible testimony of Dr. Tendai, i.e. that this baby could have survived had S. G. followed Dr. Tendai's instructions. Indeed, Dr. Cameron's testimony that further action (advanced fetal testing by a perinatologist) should have been taken beginning on November 2, 1992, is exactly in accord with what *Dr. Tendai was attempting to do.* There is no evidence in this case, nor daresay any other, suggesting that physician discipline should lie against one who has repeatedly and conscientiously tried, albeit unsuccessfully, to direct his or her patient to follow a medically necessary course of action. In fact, the Board's own employed physician testified that Dr. Tendai was not negligent.

Dr. James S. Johnson, a Board Certified OB/GYN, was hired by the Board in 1990 to serve on its medical staff. L.F. 00907, 931-933. His duties included the review and evaluation of complaints against physicians. L.F. 00909-911, 921-922. As part of his

duties for the Board, Dr. Johnson reviewed the medical records in this case and interviewed Dr. Tendai. L.F. 00911-00916, 921, 935-936. Prior to his interview of Dr. Tendai, Dr. Johnson rendered a Medical Staff Opinion, in July of 1993, when he stated the following after reviewing only the medical records:

> "This patient suffered fetal death in utero. There were several conditions including intrauterine growth retardation, a two vessel umbilical cord and an increased titre of cytomegalovirus virus. None of these would cause fetal death in utero. The pathology reports a tight nuchal cord as the probable cause of death. *There is no negligence on the part of the doctor in the care of this patient.*"

L.F. 00918 and 934 (See, Appendix 6).

Some time after Mr. Hutchings' meetings with Dr. Tendai and after Dr. Johnson's July 1993 MEDICAL STAFF OPINION, the Board's medical staff, including Dr. Johnson, interviewed Dr. Tendai at the Board's offices in Jefferson City. Dr. Tendai brought his entire file, including the sticky notes, with him. During Dr. Tendai's medical staff interview, he told the Board about his use of sticky notes and offered to send the Board information concerning his use of those notes. L.F. 00333-334, 00350-353. Dr. Tendai signed an affidavit explaining his use of the notes and forwarded same to the Board. L.F. 00352, 00900 (See, Appendix 8). The Board received Dr. Tendai's letter on October 14, 1993. L.F. 00900. Following the medical staff interview, Dr. Johnson prepared a detailed memorandum of the interview and offered the following opinion:

"Dr. Tendai made an attempt to have [S. G.] follow her care with weekly and biweekly visits, but she refused and she also refused a referral to a perinatologist as requested." L.F. 00935-937 (See, Appendix 7).

In summary, the Board's medical staff, led by Dr. James Johnson, a Board certified OB/GYN, who reviewed the medical records on two separate occasions and interviewed Dr. Tendai, concluded that: S. G. refused Dr. Tendai's referral to a perinatologist; and, Dr. Tendai was not negligent. L.F. 00934-937. The Commission ignored this testimony without comment[19].

The Commission's failure to consider this evidence is: a) an abuse of discretion; and, b) arbitrary, capricious, and unreasonable; and therefore must be reversed by this Court. *See Psychare Management, Inc. v. Dept. of Social Services*, 980 S.W.2d 311, 312 (Mo. banc 1998).

POINT III

THE BOARD OF HEALING ARTS ("BOARD") ERRED IN ITS DECISION TO IMPOSE DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE BECAUSE SUCH ORDER VIOLATES DR. TENDAI'S RIGHTS TO EQUAL PROTECTION AND BECAUSE SECTIONS 334.100.2(5) AND 334.100.2(25) ARE UNCONSTITUTIONAL UNDER THE EQUAL PROTECTION CLAUSE, IN

[19] The Commission may not ignore or arbitrarily disregard evidence without explanation. *Mineweld, Inc. v. Board of Boiler and Pressure Vessel Rules*, 868 S.W.2d 232, 234 (Mo. App. W.D. 1994).

THAT DR. TENDAI RECEIVED DISCIPLINE FAR MORE SEVERE THAN OTHER PHYSICIANS ENGAGING IN SIMILAR OR MORE SERIOUS CONDUCT, IN THAT THE BOARD'S DISCIPLINE WAS NOT RATIONALLY RELATED TO ITS OBJECTIVE OF PROTECTING THE PUBLIC, AND IN THAT SECTIONS 334.100.2(5) AND 334.100.2(25) CREATE DIFFERING CLASSIFICATION OF PHYSICIANS SUSPECTED OF INCOMPETENCE AND ESTABLISH DIFFERENT PROCEDURAL RIGHTS BASED ON THIS CLASSIFICATION.

STANDARD OF REVIEW

Dr. Tendai hereby incorporates the Standard of Review as set forth in Point I.

ARGUMENT

A. The Board's Disciplinary Order Violates Dr. Tendai's Equal Protection Rights

Section 334.100 RSMo., and the Board's application of this statute in imposing discipline upon Dr. Tendai, violate Dr. Tendai's equal protection rights guaranteed by the Fourteenth Amendment to the United States Constitution.

Differential Treatment

Even where a fundamental right is not at issue, or where a person is not a member of a "suspect" classification, a person who is treated differently from others under the law is entitled to judicial scrutiny of that law to determine whether the treatment is rationally related to a legitimate governmental interest. *See Adams Ford Belton, Inc. v. Missouri*

Motor Vehicle Comm'n., 946 S.W.2d 199, 202 (Mo.banc 1997) (internal citations omitted); *see also Artman v. State Bd. of Registration for the Healing Arts*, 918 S.W.2d 247, 252 (Mo. banc 1996); citing *Gregory v. Ashcroft*, 501 U.S. 452, 470-71, 111 S.Ct. 2395, 2406, 115 L.Ed.2d 410 (1991).

Further, the United States Supreme Court has recently enunciated the standard for finding the existence of a "class of one," such as Dr. Tendai in the present case, for purposes of equal protection analysis. If a party alleges, as Dr. Tendai alleged in the present case, that he has been intentionally treated differently from others similarly situated and that there is no rational basis for the difference in treatment, he has stated a claim under equal protection clause. *Village of Willowbrook v. Olech*, 528 U.S. 562 (2000)[20]. *Olech* states in very clear terms that a "class of one," for equal protection purposes, may exist where the party "alleges that she has been intentionally treated differently from others similarly situated and that there is no rational basis for the difference in treatment." *See* 528 U.S. at 564, quoting *Allegheny Pittsburgh Coal Co., supra*. The Supreme Court explained that the purpose of the equal protection clause of the Fourteenth Amendment "is to secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute *or by its improper execution through duly constituted agents." See id.*, quoting *Sioux City Bridge Co. v. Dakota County*, 260 U.S. 441 (1923).

[20] *See also Allegheny Pittsburgh Coal Co. v. Commission of Webster City*, 488 U.S. 336 (1989).

In *Olech*, the factual dispute involved the requirement placed on Ms. Olech by the Village of Willowbrook, a municipality, as a condition to attaching Ms. Olech's residence to the municipal water supply. While previous residents had been required to grant the municipality only a fifteen-foot easement, Ms. Olech was asked to give the village a thirty-three foot easement as a condition of using the municipal water supply. Although she alleged ill will on the part of the municipality as a result of her involvement in prior litigation against the municipality, the Supreme Court did not reach this "subjective ill will" theory but instead found her to be a "class of one" for equal protection purposes. *See* 528 U.S. at 564-65. Finding that Ms. Olech had properly pled that the municipality's requirement, applied to her alone, that a 33-foot easement be granted, (a requirement on which the village eventually relented) was without a rational basis, the Supreme Court affirmed the Seventh Circuit's judgment reversing dismissal of Ms. Olech's claims in the trial court below. *Id.*

There is no discussion in *Olech* of whether separate additional allegations regarding "classification" are necessary to assert an equal protection claim under the "class of one" theory. The U.S. Supreme Court has not, in *Olech* or elsewhere, imposed this additional burden on those litigants who *are intentionally treated differently than others similarly situated without a rational basis for the differing treatment* in a "class of one" case. In effect, the Supreme Court did allow "Ms. Olech" to constitute a class of one under equal protection analysis, because she had been treated differently than others similarly-situated by the Village of Willowbrook.

Dr. Tendai has clearly alleged and presented substantial evidence to show that he was treated more harshly than other, similarly-situated licensees of the Board, and that there was no rational basis put forth to justify this differential treatment. Further, the Board's intention to impose a more harsh discipline upon Dr. Tendai is made clear in this case by the fact that the Board was presented with, and had possession of, the evidence consisting of over eighty (80) cases in which similar or identical violations had resulted in much less severe, or no, discipline. L.F. 01182-01187; 01244-01935.

For example, the Board issued a reprimand to Dr. Jeffrey Swetnam on October 15, 1995, when his care was found to be below the acceptable medical standards by administering excessive doses of drugs that depressed the patient's respiration, causing cardiac arrest and the patient's death. Ex. 1-PP. L.F. 01470-79. Additionally, the Board reprimanded Dr. John Denton after it found that he failed to obtain assistance through a critical period of management of a patient which contributed to fetal demise during delivery. Ex. 1-a. L.F. 01578-83. Similarly, the Board reprimanded Dr. Gary Dausmann on May 28, 1997, when it concluded that his treatment of a pregnant patient was below the acceptable medical standards, resulting in a stillborn birth only one day after the doctor had examined the patient. Ex. 1-d. L.F. 01599-609. The Board also issued a public reprimand to Andres Apostol on March 8, 1999, based upon his failure to stabilize and treat a patient until surgery could be performed, resulting in the death of that patient. Ex. 1-a. L.F. 01770-76. Finally, the Board reprimanded Dr. Jessie Cooperider, on July

19, 1999, where the doctor failed to conduct an appropriate screening examination. Ex. 1-aa. L.F. 01831-38. That patient also died. *Id.*

The Board only reprimanded the license of James Stricklin, M.D., due to Dr. Stricklin's performance of an unnecessary operative procedure and writing an inaccurate history and physical to justify the surgery. Ex. 1-X. L.F. Vol. VIII pp. 01352-54. The Board also only reprimanded the license of Ian A. Kling, M.D., after the Commission found cause to discipline Dr. Kling's license due to his knowingly giving a false answer on his application to obtain privileges at Barnes St. Peters Hospital, even after the Commission made a specific finding that Kling's testimony was "inconsistent and evasive." Ex. 1-II. L.F. Vol. VIII pp. 01391-01400. The license of David S. Sneid, M.D., was only reprimanded for giving inaccurate and untrue information in connection with his application for staff privileges at St. Joseph Health Center, by failing to disclose that his Missouri medical license had been limited when, in fact, he had voluntarily surrendered his Missouri license and had it placed on probation. Ex. 1-NN. L.F. Vol. IX pp. 01440-48. The Board also only reprimanded the license of Manuel C. Hugo, M.D., based upon discipline by the New Jersey Board of Medical Examiners based upon Dr. Hugo's failure to notify the parents of an infant patient of an abnormal test result relating to PKU testing; based upon a consent agreement which he entered into with the Maine Board of Registration and Medicine due to his failure to report his New Jersey discipline on his Maine licensure renewal applications on three separate occasions; and, due to his

false statement on his Missouri application wherein he stated that he had not had his license disciplined by any other state. Ex. 1-OO. L.F. Vol. IX pp. 01449-59.

The Board only reprimanded the license of Debra K. Duello, M.D., based upon Dr. Duello's admissions that she engaged in conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public, incompetency, gross negligence or repeated negligence in the performance of the function or duties of her profession, due to her failure to diagnose a patient's pregnancy, in spite of numerous examinations between April 1, 1993, and August 12, 1993, at which time she performed a hysterectomy on the patient which was contraindicated and fell below the acceptable medical standards of practice, resulting in the demise of the fetus. Ex. 1-WW. L.F. Vol. IX pp. 01525-30.

The Board also only reprimanded the license of Allen S. Wasserman, M.D., based upon discipline by the Texas State Board of Medical Examiners which was premised upon Dr. Wasserman's poor judgment in transporting an unstable OB patient and use of an improper instrument in a circumcision. Furthermore, the doctors privileges at a hospital were revoked for leaving the operating room for thirty-five minutes with the patient anesthetized and intubated in spine lithotomy position with laproscopic trocar sheaths remaining in the abdomen. Ex. 1-c. L.F. Vol. IX pp. 01590-98.

The license of Frank Chow, M.D., was only reprimanded after the Commission found that Dr. Chow had been found guilty of sexual battery; and, that Dr. Chow

knowingly used false statements on his Kansas and Missouri applications in an effort to fraudulently obtain a license. Ex. 1-w. L.F. Vol. XI pp. 01784-99.

The Board only reprimanded the license of Arthur N. Lee, Jr., M.D., over the death of his patient following the doctor's admission that his conduct fell below the accepted standards of care by failing to perform certain tests on the patient, failing to return calls of another physician concerning the patient's health, failing to consult with another physician concerning the patient's health, and failing to forward the patient's medical records to another physician. Ex. 1-x. L.F. Vol. XI pp. 01800-07.

The Board also reprimanded the license of Michael E. Blank, M.D., based upon his violation of the drug laws or rules of Missouri and conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient resulting from his care and treatment of five different patients wherein he overprescribed controlled substances and failed to adequately document data concerning these prescriptions, examinations and diagnoses. Ex. 1.z. L.F. Vol. XI pp. 01818-30.

The Board elected not to discipline the license of Dalrie Berg, D.O., even though the Colorado Board of State Medical Examiners placed Dr. Berg's license on probation for five years and ordered Dr. Berg not to engage in the practice of obstetrics based upon two or more acts or omissions by Dr. Berg which failed to meet the generally accepted standards of medical practice. Ex. 1-dd. L.F. Vol. XI pp. 01855-57.

The Board also elected to impose no discipline against the license of Marcellus Lawrence, M.D., even though the Commission found cause to discipline his license,

based upon his conviction of an offense involving moral turpitude wherein he pleaded guilty to driving under the influence three times within a three year period, and based upon Dr. Lawrence's misrepresentation to the Board that he had not been arrested or pleaded guilty to DUI charges. Ex. 1-ee. L.F. Vol. XI pp. 01858-74.

The Board elected to impose no discipline against Valentino Andres, Jr., M.D., even after the Commission found cause to discipline his license based upon his plea of "no contest" in California to charges of sexual exploitation of a patient by a psychotherapist and the imposition of discipline upon his license by the state of California, including seven years of probation. Ex. 1-ff. L.F. Vol. XI pp. 01875-81.

The Board also elected to impose no discipline against the license of Frank Campobasso, D.O., even though the Commission found cause to discipline his license based upon restrictions imposed upon his controlled substance authority by the Missouri Bureau of Narcotics and Dangerous Drugs ("BNDD") and based upon his violation of a Memorandum of Understanding which he entered into with BNDD. Ex. 1-gg. L.F. Vol. XI pp. 01882-1947.

Finally, the Board elected to impose no discipline against the license of Rex T. Martin, D.O., even though the Commission found cause to discipline his license based upon disciplinary action by the Maine Board of Osteopathic Licensure due to his violation of his consent agreement with the Maine Board. The consent agreement in Maine was based upon dispensing controlled substances in unlabeled envelopes; prescribing large quantities of controlled substances to a number of patients and

continuing to prescribe scheduled drugs to some patients without adequate medical justification in his records; treatment of patients with controlled substances without attempting other treatment modalities, ordering lab tests or obtaining consultations; and, failing to obtain complete medical histories and make detailed physical findings in his progress notes. Under the Maine Consent Agreement, Dr. Martin was not to prescribe controlled substances without following certain conditions. Dr. Martin violated those conditions. Nonetheless, the Missouri Board elected to impose no discipline. Ex. 1-hh. L.F. Vol. XI pp. 01915-19.

As these cases illustrate, the Board has had numerous other cases where physicians have been found to have been incompetent and grossly negligent, and have been found to have engaged in conduct harmful or dangerous to a patient and repeatedly negligent, and have only been reprimanded by the Board. Furthermore, in some of these cases, physicians were specifically found to have been less than candid with the Board or the Commission. However, the Board chose, in those cases, only to reprimand or impose no discipline. Based upon the evidence before the Board, Dr. Tendai received disparate discipline without justification.

The Board's intentions were also made clear by the demands by its counsel, during closing arguments at the disciplinary hearing, that the Board needed to "punish" Dr. Tendai for his violations of the practice act. L.F. 01177.

Dr. Tendai was not required, pursuant to *Olech* or *Allegheny Pittsburgh Coal Co., supra*, to additionally allege and show that he had been improperly "classified" by the

Board or its laws, so long as he alleged that he was intentionally treated differently than others similarly situated, and that his differing treatment lacked a rational basis. Therefore, pursuant to the holdings of the United States Supreme Court in the *Olech* and *Allegheny Pittsburgh Coal Co.*, Dr. Tendai has established an equal protection claim based on the evidence which reveals that the Board, in intentionally imposing discipline upon his license which was much more harsh in nature than the discipline it chose to impose on other physicians engaging in similar conduct, has treated Dr. Tendai differently than those other similarly-situated physicians. No further "classification" need be shown by Dr. Tendai. The remaining element of Dr. Tendai's equal protection claim concerns whether the Board had any rational basis for its differential treatment of his license in this matter.

No Rational Basis

Professional licensing laws, such as those found in Chapter 334, are remedial in nature, and are enacted for the welfare of the public. *See Bhuket v. State Bd. of Registration for the Healing Art*s, *supra*. Here, it cannot be disputed that the general goal of protecting the public from incompetent physicians (as embodied in §334.100) is a "legitimate governmental interest" for purposes of equal protection analysis, which has been legislatively granted to the Board by enactment of Chapter 334, RSMo. However, the Board's application of §334.100 to Dr. Tendai violates equal protection principles in two respects.

First, as applied to Dr. Tendai, the discipline ultimately ordered by the Board pursuant to §334.100 bears no "rational relationship" to the Board's interest in protecting the public. This is because the Board had no evidence before it upon which to believe that Dr. Tendai posed any threat to the public. The only evidence as to Dr. Tendai's ability to safely and competently continue his practice was that which he presented, which evidence establishes that Dr. Tendai is an asset to the medical community and that he enjoys an excellent reputation among his colleagues and within his community generally. In other words, the Board had no basis to conclude that the public welfare was in jeopardy, and thus had no governmental interest to "protect" via the suspension and restriction of Dr. Tendai's license. Coupled with this is the fact that the Board made no effort to distinguish the facts of Dr. Tendai's case from those of the many other disciplinary cases it had previously handled, in which other physicians had received no discipline or only minimal discipline for similar conduct reaching similar results. (*See* discussion above). Moreover, the Board presented *no* evidence whatsoever to support its implicit conclusion that Dr. Tendai, posed any greater "threat" to the public than all those other physicians engaging in remarkably similar conduct, who received either no discipline or only a reprimand.

The only evidence before the Board relating to Dr. Tendai's professional and personal reputation was that which Dr. Tendai himself presented. Notably, Dr. Tendai demonstrated, among other things, that he enjoyed a reputation in the community generally and among his professional peers, as being a truthful, trustworthy and caring

person, and a skilled, competent and dedicated physician and surgeon; and, that he carefully and conscientiously attended to the care and treatment of his patients. *See* Affidavits of Drs. Domann, L.F. 01193-01195; Egbert, L.F. 01196-01197; Halverson, L.F. 01198-01199; and, Haen, L.F. 01200-01201; *see also* Affidavit of Joe Huntsman, L.F. 01202-01204. This evidence further revealed that Dr. Tendai was strongly respected by his peers. *Id*. Dr. Haen, in fact, had selected Dr. Tendai to be the gynecologist for Dr. Haen's wife. L.F. 01200-01201.

According to the evidence before the Board, Dr. Tendai enjoyed a strong reputation and had not been the subject of any patient complaints since his treatment of S. G. in 1992 and J. W. in 1992 and 1993. *Id.* There was a total absence of contradictory evidence suggesting that the public interest would in any way be jeopardized by his remaining in practice.

By having his license suspended and severely restricted in scope, Dr. Tendai was clearly treated differently from other physicians engaging in conduct similar to that alleged in this case. As such, the Board's disciplinary action bears no rational relationship to any interest it apparently believed it had to protect the public from Dr. Tendai to any greater degree than other similarly situated physicians, and thus the Board's decision must be reversed on equal protection grounds.

B. Section 334.100.2(5) and (25) Are Unconstitutional Under the Equal Protection Clause.

Secondly, subdivisions (5) and (25) of §334.100.2 are themselves constitutionally infirm under equal protection analysis. These provisions each concern the Board's authority with regard to physicians found or believed to be "incompetent." However, these provisions create two different classifications of physicians suspected of incompetence in their conduct. Section 334.100.2(5) authorizes Board discipline for those physicians found culpable of specific medical misconduct in an action before the Commission, while §334.100.2(25) creates a specific set of procedures to be undertaken by the Board in cases where a physician is suspected of "general medical incompetency." *See Artman*, 918 S.W.2d at 250. For determination of the latter inquiry, the Board is authorized to conduct a "probable cause" hearing initially, as well as a subsequent hearing to determine whether the license should be revoked following a full Board investigation. 918 S.W.2d at 250-51. Further, the Board has enacted regulations implementing these procedures, as more fully discussed elsewhere herein. Taken together, the procedures allowed by §334.100.2(25) and regulations thereunder allow a physician suspected of general medical incompetence to prove, by successfully completing certain additional examination requirements, that he is professionally competent to remain in practice. However, this procedure is denied to those physicians, such as Dr. Tendai, who are charged with incompetence based upon specific medical conduct. Such differentiation among these separate classes of physicians clearly violates equal protection standards because the distinct procedures allowed to physicians falling under §334.100.2(25) bears no rational relationship to the state's interest in protecting its

citizens from incompetent physicians. To hold otherwise would require a conclusion that physicians who have engaged in specific instances of medical conduct are somehow more (or less) likely to be a danger to the public than those who are "generally" incompetent. Such a conclusion defies logic, and lacks any factual basis – the Board's interest in protecting the public from "incompetent" physicians is exactly the same, regardless of whether the suspected incompetence is limited to specific instances or of a more general nature. There is thus no justification for providing different procedures for disciplinary action relating to these two classes of physicians, and subdivisions (5) and (25) cannot be read in any manner so as to reconcile this equal protection infirmity. *See Artman*, 918 S.W.2d at 251. As a result, these provisions are facially unconstitutional. They are also unconstitutional as applied by the Commission and the Board of Healing Arts.

Summary

Thus, because Dr. Tendai was intentionally treated differently than numerous other similarly-situated physicians appearing before the Board, and because the Board has not, and indeed cannot, show any rational basis for its differential treatment of Dr. Tendai, the Board's disciplinary order must be reversed pursuant to the holdings of the United States Supreme Court in the *Olech* and *Allegheny Pittsburgh Coal* opinions. Additionally, Sections 334.100.2(5) and (25) are facially unconstitutional for the reasons discussed above.

POINT IV

THE CIRCUIT COURT ERRED IN ITS JUDGMENT DENYING DR. TENDAI'S CLAIM THAT THE BOARD'S DISCIPLINARY ORDER VIOLATED DR. TENDAI'S RIGHTS TO EQUAL PROTECTION BECAUSE THE JUDGMENT WAS UNAUTHORIZED BY LAW; WAS ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVED AN ABUSE OF DISCRETION; AND, WAS UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD, IN THAT THE BOARD'S DISCIPLINARY ORDER INTENTIONALLY IMPOSED DISPARATE DISCIPLINE AGAINST DR. TENDAI WHICH WAS FAR MORE HARSH THAN THE DISCIPLINE THAT THE BOARD IMPOSED ON SIMILARLY SITUATED PHYSICIANS WITH NO RATIONAL BASIS FOR THE DISPARATE TREATMENT.

STANDARD OF REVIEW

As addressed in Points I -III, in this kind of appeal this Court generally must review the underlying decisions of the administrative agencies (in this case the combined decisions of the Administrative Hearing Commission and Board), and not the decision of the Circuit Court on judicial review, from which this appeal is taken. *See, e.g., State Bd. of Reg'n. for the Healing Arts v. McDonagh,* 123 S.W.3d 146 (Mo. banc 2003). However, in this Point Dr. Tendai is forced to challenge directly the Findings of Fact, Conclusions of Law and Judgment rendered by the Circuit Court on June 1, 2004

("Judgment") because it was at that juncture that Dr. Tendai's equal protection/disparate treatment claims were first capable of being adjudicated. As this Court itself previously explained in this case:

> ". . . Judicial review of an equal protection claim, unlike review of more common claims, such as those based on insufficiency of the evidence . . . are not and cannot be dependent upon agency findings of fact. *This is so because the factual determinations necessary in the equal protection claim – the comparison of the punishment in the case at hand with punishments meted out for similarly situated parties – can only be undertaken after the Board completes its work by imposing punishment.* Indeed, an aggrieved party cannot plead or prove that other punishments are disparate until the punishment for that party has been imposed. *For this reason, equal protection claims of this kind must be heard and decided in the first instance by the circuit court rather than the board, and it is the circuit court, rather than the board, that is the fact finder."*

See Missouri State Bd. of Reg'n. for the Healing Arts v. Brown, No. SC85285 (Appendix A at p. A-49) (emphasis added).

Therefore, this Court must, in addition to reviewing the decisions of the Commission and Board as addressed in Points I – III and V, also review the Circuit

Court's decision denying Dr. Tendai's equal protection/disparate treatment claims, because this issue was clearly not reached in the underlying administrative decisions.[21]

This Court's review of the Circuit Court's Judgment must therefore determine whether that decision:

(1) Is in violation of constitutional provisions;

(2) Is in excess of the Court's statutory authority;

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[21] In accord, *see Westwood Partnership v. Gogarty*, 103 S.W.3d 152 (Mo. App. E.D. 2003), in which the Court of Appeals reached the following conclusion:

"As a general rule, on appeal from a circuit court's review of an administrative decision, this Court reviews the decision of the administrative agency, not the judgment of the circuit court . . . [f]urther, while as a general rule judicial review of the decisions of administrative agencies is limited to matters that arose before the agency and deals only with questions of law on the face of the record, barring consideration of evidence other than that before the agency, by statute a court may hear and consider evidence of alleged irregularities in the proceedings or agency unfairness *not shown in the record.* . . [d]eciding constitutional issues is beyond the authority of an administrative agency, and the courts must review agency actions that present constitutional questions. . . *[o]ur review of a constitutional issue raised before an administrative agency must, perforce, be a review of the circuit court's decision on the constitutional question.*" [Citations omitted; emphasis added].

Gogarty, 103 S.W.3d at 161-62.

(3) Is unsupported by competent and substantial evidence upon the whole record;

(4) Is, for any other reason, unauthorized by law;

(5) Is made upon unlawful procedure or without a fair trial;

(6) Is arbitrary, capricious or unreasonable;

(7) Involves an abuse of discretion.

See Section 536.140.2, RSMo. 2000.

ARGUMENT

The Circuit Court's Judgment Misapplies Disparate Treatment Standards

Following this Court's decision in the writ proceeding (No. SC85285), the Circuit Court proceeded to hear the parties' arguments concerning Dr. Tendai's equal protection/disparate treatment claims. Thereafter, the Circuit Court issued its Judgment denying these claims and affirming the Decisions of the Commission and Board in their entirety. The crux of that Judgment, concerning the denial of the equal protection claims, is expressed in the following excerpt from the Judgment:

> " . . . the Board is allowed to impose qualitatively different discipline. Therefore, Petitioner's evidence regarding the discipline imposed against others is only helpful to his case if he shows that the Board held a specific intent to single him out for different treatment. Petitioner's only basis for his claim is that the discipline imposed was more severe from what was offered before litigation commenced. This is inadequate." (emphasis added)

See Appendix A, p. A-40.

The Circuit Court's determination distorts Dr. Tendai's disparate treatment claims, and also misconstrues the holdings of the United States Supreme Court in the *Olech* and *Allegheny Pittsburgh Coal Co.* cases, *supra* and this Court's opinion in the writ proceeding in SC85285.

Specifically, throughout the long appellate history of this case Dr. Tendai has consistently alleged that the Board desired to "punish" him improperly via the disciplinary proceedings, and therefore that the Board did "single him out."

Second, the Circuit Court misreads the holding in the *Olech* opinion to require some subjective ill will by the Board to "single out" Dr. Tendai, in order to support the "class of one" equal protection theory affirmed in that case. The U.S. Supreme Court, in *Olech*, affirmed the application of the "class of one" equal protection analysis without relying on the "subjective ill will" theory which the lower court had relied upon in finding a violation of Ms. Olech's equal protection rights. It was sufficient, in the Supreme Court's view, that the facts of that case showed that Ms. Olech's differential treatment by the Village of Willowbrook was "irrational and wholly arbitrary." *See* 528 U.S. at 565. This is quite a different standard than that applied by the Circuit Court in this matter, which apparently was looking for ironclad proof of subjective ill will on the part of the Board.

Thus, as to Dr. Tendai's equal protection claims regarding the Board's disciplinary decision, the Circuit Court's judgment was erroneous in two major respects, because: 1)

Dr. Tendai was not required to prove subjective ill will on the Board's part (i.e., that he was "singled out"); and 2) even assuming that such requirement existed, Dr. Tendai demonstrated such ill will on the Board's part.

The law of Missouri is well-established with regard to disciplinary proceedings involving professional licensees. Such proceedings, and the laws which authorize them, are remedial in nature and are enacted for the public welfare; their purpose is not to levy punishment against the licensee. *See Bhuket v. State Bd. of Registration for the Healing Art*s, *supra*.

Here, the record reveals that the Board previously offered to settle this case with a public reprimand. Then, after the hearing before the Commission, the Board withdrew that offer and, during oral argument before the Board, the Board's trail counsel demanded that the Board impose some form of "punishment" on Dr. Tendai. These two facts alone are sufficient to demonstrate that the Board was ignoring long-established case law by punishing Dr. Tendai rather than protecting the public.

On top of this, however, are the eighty (80) cases offered by Dr. Tendai that demonstrate the disparate discipline which the Board imposed upon him. While the Circuit Court attempted to dismiss broad categories of these cases because they were cases involving negotiated settlements, cases based upon discipline in other states, or cases based upon criminal convictions, the Circuit Court completely failed to demonstrate how the Board was justified in imposing disparate punishment against Dr. Tendai when compared to these similar cases.

For example, the Board issued a reprimand to Dr. Jeffrey Swetnam on October 15, 1995, when his care was found to be below the acceptable medical standards by administering excessive doses of drugs that depressed the patient's respiration, causing cardiac arrest and the patient's death. Ex. 1-PP. L.F. 01470-79. Additionally, the Board reprimanded Dr. John Denton after it found that he failed to obtain assistance through a critical period of management of a patient which contributed to fetal demise during delivery. Ex. 1-a. L.F. 01578-83. Similarly, the Board reprimanded Dr. Gary Dausmann on May 28, 1997, when it concluded that his treatment of a pregnant patient was below the acceptable medical standards, resulting in a stillborn birth only one day after the doctor had examined the patient. Ex. 1-d. L.F. 01599-609. The Board also issued a public reprimand to Andres Apostol on March 8, 1999, based upon his failure to stabilize and treat a patient until surgery could be performed, resulting in the death of that patient. Ex. 1-u. L.F. 01770-76. Finally, the Board reprimanded Dr. Jessie Cooperider, on July 19, 1999, where the doctor failed to conduct an appropriate screening examination. Ex. 1-aa. L.F. 01831-01838. That patient also died. *Id.*

The Circuit Court ignored these cases, and others, where the actions by physicians directly resulted in the delivery of stillborns or the death of patients.[22]

More troubling, however, is the Circuit Court's distortion of Dr. Tendai's claim, to wit:

[22] For a more detailed discussion of other similar cases see pages 90-95 of this brief.

> "Petitioner has offered no credible evidence of intent, ill will, animus, or vindictiveness on behalf of the board or it's [sic] members . . . Petitioner asserts ill will can be imputed to the Board since it imposed more severe discipline than was offered during settlement negotiations . . . [t]his Court rejects such an inference."

See Judgment, Appendix A at pp. A-30-31.

As noted above, Dr. Tendai's ability to establish himself as a "class of one" for equal protection purposes clearly does not require that he prove "intent, ill will, animus, or vindictiveness" on the Board's part. *See Olech*, *supra*. Further, the very essence of Dr. Tendai's equal protection claim in this matter is that he was treated differently by the Board as compared with other similarly-situated licensees, and that there was no rational basis for this differing treatment – not, as the Circuit Court characterized, that the Board was singling him out in some way. The success of Dr. Tendai's equal protection claim in no way hinges on whether the Circuit Court believed that he was "singled out" by the Board as a result of ill will on the Board's part. Even if the Circuit Court believed there was no evidence of the Board's animosity, it still was required to determine, aside from any issue concerning the Board's motives: 1) whether Dr. Tendai was treated differently by the Board than 2) other similarly-situated physicians facing license discipline, and whether 3) the Board had shown any rational basis for treating Dr. Tendai differently than those other similarly-situated physicians. By focusing exclusively on the issue of the Board's subjective intent and motives, the Circuit Court's judgment misapplies the

Olech opinion and analysis, and erroneously concludes that Dr. Tendai had failed to establish himself as a "class of one" for equal protection purposes.

Had the Circuit Court applied the correct legal standard, then it would have concluded that there was no rational basis for the Board to punish Dr. Tendai when it had imposed only minimal, if any, discipline for similarly situated physicians. For these reasons, the Circuit Court's Judgment must be reversed.

POINT V

THE BOARD ERRED IN ITS ORDER IMPOSING DISCIPLINE UPON DR. TENDAI'S MEDICAL LICENSE BECAUSE THE ORDER WAS MADE UPON UNLAWFUL PROCEDURE; WAS UNAUTHORIZED BY LAW; WAS ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVED AN ABUSE OF DISCRETION; AND, WAS UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE UPON THE WHOLE RECORD, IN THAT THE BOARD: (A) FAILED TO SET FORTH IN ITS FINDINGS AND CONCLUSIONS ANY BASIS FOR ITS DISCIPLINARY ORDER; (B) FAILED TO FOLLOW ITS ANNOUNCED PROCEDURE; (C) ORDERED DISCIPLINE UPON DR. TENDAI'S LICENSE IN THE ABSENCE OF COMPETENT AND SUBSTANTIAL SUPPORTING EVIDENCE; (D) ACTED UNLAWFULLY IN CLOSING ITS DISCIPLINARY DELIBERATIONS; (E) FAILED TO ALLOW DR. TENDAI TO DEMONSTRATE HIS COMPETENCY PURSUANT TO

STATUTORY PROCEDURE; AND, (F) FAILED TO OBSERVE STATUTORY PROCEDURAL REQUIREMENTS.

STANDARD OF REVIEW

Dr. Tendai hereby incorporates the Standard of Review as set forth in Point I.

ARGUMENT

A. The Board's Findings of Fact and Conclusions of Law are legally insufficient and provide no basis for the discipline imposed.

The document issued by the Board on May 15, 2000, which purports to impose discipline upon Dr. Tendai's license, does not comply with Missouri law establishing the requirements for agency decisions. L.F. 01935, see Appendix 2.

It is axiomatic that "to present a subject for appellate review, the written decision of the administrative agency must show how the controlling issues have been decided." *Heinen v. Police Personnel Bd. of Jefferson City*, 976 S.W.2d 534, 539 (Mo. App. W.D. 1998). Administrative agency findings in a contested case must constitute a factual resolution of the matters being contested before the agency; they must advise the parties and circuit court of the factual basis upon which the agency reached its conclusion and order; they must provide a basis for the circuit court to perform its function in reviewing the agency's decision, and show how controlling issues have been decided; and, a summary of testimony, a statement of the agency's ultimate conclusions, or a mere chronology of events is insufficient to accomplish these purposes. *Weber v. Fireman's Retirement System*, 899 S.W.2d 948, 950 (Mo. App. E.D. 1995). An agency's findings

must be sufficiently specific to enable a reviewing court to do so intelligently and to determine if the facts provide a reasonable basis for the decision without an independent search of the record by the court; a reviewing court is not permitted to presume that the agency found the facts in accordance with the result reached. *Heinen*, 976 S.W.2d at 539-540.

The Board's attempted "Findings of Fact, Conclusions of Law and Order", (the "Disciplinary Order" hereafter) quite simply fail to accomplish these purposes. First, although captioned as such, the Disciplinary Order contains no delineated "findings of fact", but merely recites only a brief procedural history of the proceedings entitled "Statement of the Case". L.F. 01935-39. In its "Statement of the Case", which was the introductory portion of the Disciplinary Order, the Board found that a) the AHC had issued its Findings of Fact and Conclusions of Law concluding that Dr. Tendai's license was subject to discipline, and that the AHC order was incorporated within the Board's order; b) the Board had received the AHC's record of proceedings; c) the Board had properly served Dr. Tendai with notice of its disciplinary hearing; d) the Board held a hearing for the purpose of determining appropriate disciplinary action against Dr. Tendai, at which the parties were represented by counsel; e) each Board member certified that he/she had read the AHC order, and that each Board member had attended the disciplinary hearing and participated in the Board's "deliberations, vote and order," and f) Dr. Tendai is currently licensed by the Board. L.F. 01935-36. The Board's "Conclusions of Law" were simply that a) the Board has jurisdiction over the disciplinary proceeding,

and b) Dr. Tendai's license is subject to disciplinary action by the Board. L.F. 01936-37. Neither the "Statement of the Case" nor "Conclusions of Law" contain any reference to specific evidence or facts on which the Board relied in determining the nature of Dr. Tendai's discipline. The "statement" section is merely a brief procedural chronology of the case prior to the Board's disciplinary hearing. L.F. 01935-36. Regardless of these omissions, the Board ordered that Dr. Tendai's license be publicly reprimanded, and that his license be suspended for a period of sixty (60) days from the order's effective date of May 15, 2000. L.F. 01937. Dr. Tendai was also restricted from ever again practicing obstetrics or obstetrical procedures in the state of Missouri, and was required to attend a medical documentation course. L.F. 01937-38. The Board's order also provided for additional discipline in the event of future violations by Dr. Tendai. *Id.*

Clearly, the opportunity for meaningful and intelligent review is denied to Dr. Tendai, and this Court, by the scant nature of the Board's Disciplinary Order. The Disciplinary Order provides no basis for the ultimate conclusion reached by the Board, that being Dr. Tendai's discipline. It is rather only a "mere chronology of events" with a statement of the Board's ultimate conclusion, which is insufficient under the aforementioned standards. *See Weber v. Fireman's Retirement System, supra*. The Order does not show how the controlling issue (i.e., discipline) was decided, and is not sufficiently specific to allow this Court to determine if there is a reasonable basis in fact for the disciplinary decision reached. To do so, this Court would be required to resort to a review of the evidence which might support the Board's decision, which is of course

prohibited. *Conlon Group, Inc. v. City of St. Louis*, 944 S.W. 2d 954 (Mo. App. W.D. 1997). Accordingly, this Court must reverse and remand the Board's Disciplinary Order for additional findings of fact and conclusions of law consistent with this Court's decision herein.

B. The Board failed to follow its announced procedure of reading portions of the trial record identified by Plaintiff.

As previously detailed in Dr. Tendai's Statement of Facts, the President of the Board told Dr. Tendai's counsel and the Board's counsel that he and the other members of the Board would read any portions of the transcript from the Commission which were cited to the Board by counsel. L.F. 01129. Dr. Tendai's counsel requested the Board to read Dr. Tendai's testimony; the testimony of Dr. Tendai's expert, Dr. Griffin; and, the cross-examination of S. G. Dr. Tendai's counsel also requested the members of the Board to review its previous decisions in some eighty (80) cases which Dr. Tendai offered into evidence. L.F. 01152, 01178, 01188. In these cases, the Board offered minimal, if any, discipline against physicians wherein cause for discipline had been determined. L.F. 01181-87; H.A. Exs. 1-B through 1-jj; L.F. 01244-01934. The fact that the Board conducted all of its deliberations on the same day as the public hearing, L.F. 01976, together with the sheer volume of the evidence which Dr. Tendai's counsel requested the members of the Board to review (more than 800 pages), strongly suggests that the members of the Board did not review that evidence. The absence of any record of the deliberations to confirm their review of this evidence, as well as the absence of any

mention of the evidence in the Board's decision, leads to the conclusion that the members of the Board ignored that evidence, even if they reviewed same. The failure of the Board to follow its announced procedure denied Dr. Tendai the right to a fair hearing in violation of Section 536.140.2(5). In the event that the Board considered the evidence, it ignored same. The Board may not ignore or arbitrarily disregard undisputed evidence without explanation. *Mineweld, Inc., v. Board of Boiler and Pressure Vessel Rules*, 868 S.W.2d 232, 234 (Mo. App. W.D. 1994). The Disciplinary Order should, therefore, be reversed.

C. The discipline imposed by the Board is unsupported by competent and substantial evidence upon the whole record, and constitutes an abuse of discretion by the Board.

The purpose of Section 334.100, RSMo. (authorizing discipline of licensed physicians) is to protect the public, and thus this statute is not penal in nature. *Younge v. State Bd. of Registration for the Healing Arts*, 451 S.W.2d 346, 349 (Mo. 1969) *cert. denied* 90 S.Ct. 910. In *Bhuket v. State Bd. of Registration for the Healing Arts*, 787 S.W.2d 882, 885 (Mo. App. W.D. 1990), the Court of Appeals explained as follows:

> "Statutes authorizing the Missouri State Board of Registration for the Healing Arts to regulate and discipline physicians are remedial statutes enacted in the interest of the public health and welfare and must be construed with a view to suppression of wrongs and mischiefs undertaken to be remedied."

Id. In reaching its decision concerning the discipline of Dr. Tendai's license, the Board was thus required to be guided by these principles of construction. However, in applying a "public protection" analysis to the Board's Disciplinary Order, it is apparent under the circumstances of this case that the Board was not motivated primarily by public protection, but rather by a desire to punish Dr. Tendai for his conduct in a case involving tragic (if not disciplinable) facts.[23]

During the disciplinary hearing, the Board's counsel (apparently ignoring the standards described above) urged the Board that "this case deserves some discipline in the form of **punishment."** L.F. 01177 (emphasis added). This was based on his own assessment that Dr. Tendai simply stood by, saying nothing and taking no action, while S. G.'s baby headed toward its demise as a result of IUGR. L.F. 01174-76. However, Board counsel's conclusion, like that of the Commission, absolutely depends on two propositions: one, that Dr. Tendai contrived the "sticky notes" regarding S. G.'s uncooperative demeanor with him[24], and two, that under any circumstances, Dr. Tendai

[23] The Board may have also been motivated by its belief that Dr. Tendai acted "defiantly" in his appearance before the Board. This assertion was made by Board Counsel during oral arguments conducted before the Circuit Court following this Court's remand in Case No. SC85285. There are no facts in the record to support the Board's recent claim of "defiance." However, even assuming *arguendo* that Dr. Tendai was in any way "defiant," that would not be a justification for disparate discipline.

[24] *See* fn. 10, *supra*.

could not possibly have discussed IUGR and specialty referral with S. G. simply because written evidence of these discussions does not appear in the patient's records. Dr. Tendai, however, presented evidence to the Board which refutes these propositions and which further reveals his good character as a physician, yet the Board apparently followed the path of punishment, rather than public protection, and assessed significant discipline against Dr. Tendai's license.

Dr. Tendai testified that in his practice career spanning over thirty years, he had been the subject of four malpractice payments on his behalf, two of which arose from his treatment of the patients involved in the Commission case underlying this review proceeding. L.F. 01156-57. He has been the subject of no other disciplinary or malpractice actions since his treatment of S. G. in 1992. L.F. 01157. Dr. Tendai continues to accept Medicaid patients in his practice, whom he testified receive the same level of care and treatment that his other patients receive. L.F. 01156. While not attempting to relitigate issues tried before the Commission, Dr. Tendai explained that he is motivated by ethical concerns to write subjective information about patient demeanor and conduct on "sticky notes", rather than in the patients' actual chart, so that this kind of information will not be "where everybody can see it." L.F. 01156; 01168-70. Dr. Tendai continues to follow this approach, in the interest of protecting the patient's physician-patient privilege. L.F. 01158. He believes "firmly" in protecting this privilege. *Id*. Despite this, the Board has chosen to overlook Dr. Tendai's testimony, in essence finding no justification for his desire to protect his patients' confidentiality in this manner.

Dr. Tendai also presented the Board with evidence of his excellent professional standing, in the form of five testimonial affidavits, four of which were from professional colleagues. L.F. 01160-62. Finally, Dr. Tendai presented extensive evidence to the Board revealing numerous previous disciplinary decisions, many of which rendered under facts strikingly similar to this case, in which the Board elected to impose only minor discipline or no discipline at all. L.F. 01182-01187. This evidence alone reveals the arbitrariness of the Board's discipline against Dr. Tendai. In particular, evidence was presented showing that the Board had previously only reprimanded physicians whose patients had died due to the physicians' omissions, including at least two previous reprimands to physicians whose conduct had led to stillborn babies. *Id*.; L.F. 01185. Again, the Board made no effort in its Disciplinary Order to explain why the circumstances of Dr. Tendai's case justified the imposition of a sixty-day suspension, coupled with a public reprimand and an order that he be barred from ever again practicing obstetrics. L.F. 01937-38. Particularly in view of the Board's failure to explain any of its reasoning, there can be no conclusion but that the discipline imposed upon Dr. Tendai was an arbitrary, capricious and unreasonable decision by the Board, which was reached due to the Board's desire to "punish" Dr. Tendai. As such, the Board's decision cannot stand. *See Americare Systems, Inc. v. Missouri Dept. of Soc. Services*, 808 S.W.2d 417, 419 (Mo. App. W.D. 1991).

The unreasonableness of the Board's Disciplinary Order is further revealed by the fact that the Board's counsel did not produce, and there was not before the Board, one

shred of evidence suggesting that the public needs "protecting" from Dr. Tendai's continued practice. Were such evidence to exist, the Board's counsel would have presented that evidence to the Board. To the contrary, the only evidence before the Board relating to Dr. Tendai's professional and personal reputation was that which Dr. Tendai himself presented. Notably, Dr. Tendai demonstrated, among other things, that he enjoys a reputation in the community generally and among his professional peers, as being a truthful, trustworthy and caring person, and a skilled, competent and dedicated physician and surgeon; and, that he carefully and conscientiously attends to the care and treatment of his patients. *See* Affidavits of Drs. Domann, L.F. 01193-95; Egbert, L.F. 01196-97; Halverson, L.F. 01198-99; and, Haen, L.F. 01200-1201; *see also* Affidavit of Joe Huntsman; L.F. 01202-04. This evidence further reveals that Dr. Tendai is strongly respected by his peers. *Id*. Dr. Haen, in fact, has selected Dr. Tendai to be his own wife's gynecologist. L.F. 01200-1201.

In view of the overwhelming evidence of Dr. Tendai's strong reputation, coupled with his lack of any patient complaints since his treatment of S. G. in 1992 and the total lack of any contradictory evidence suggesting that the public interest would in any way be jeopardized by his remaining in practice, the Board clearly abused its discretion in electing to impose the chosen discipline upon Dr. Tendai. The Board's decision flies in the face of the overwhelming evidence of record, in addition to the long line of previous similar cases in which physicians were allowed to remain in practice. Finally, the Board's discipline, along with its necessary implication that Dr. Tendai's continued

practice somehow poses potential harm to the public, is soundly refuted by the fact that the Board previously made an initial offer to settle its disciplinary complaint for a **reprimand** of Dr. Tendai's license. L.F. 73. The Board obviously could not have believed when it made this offer that Dr. Tendai was unfit to continue practicing, or it would have offered only disciplinary terms that would have put him out of practice, which a reprimand does not accomplish.

Dr. Tendai is not the first physician who justifiably sought relief from the heavy-handed discipline of the Board of Healing Arts. In 1982, the Board of Healing Arts revoked the license of Zane Gard, D.O., after the Commission concluded that Dr. Gard had been convicted of a crime connected with the practice of his profession and that his license to practice medicine in California had been revoked. *Gard v. State Board of Registration for the Healing Arts*, 747 S.W.2d 726, 728 (Mo.App. W.D. 1988). Dr. Gard contended that the Board's decision was unsupported by competent and substantial evidence upon the whole record, was arbitrary, capricious, or unreasonable, and involved an abuse of discretion. The Court of Appeals reversed the Board's revocation of Dr. Gard's license and remanded the case to the Board for imposition of terms of probation as may be deemed appropriate. *Gard*, at 730. Therein, the court stated the following concerning the abuse of discretion claim:

> "An abuse of discretion may be found in either case by adverting to the substantial evidence adduced before the AHC, and of course, any additional

evidence given before the Board when it is called upon to exercise a discretion under §621.110."

Gard, 747 S.W.2d at 729. Applying that standard, the appellate court observed that the record was replete with evidence of Dr. Gard's rehabilitation, which was undisputed, and, "under the particular facts here," concluded that the Board had abused its discretion. *Id*.

The Eastern District of the Court of Appeals took this reasoning one step further in *Boyd v. State Board of Registration for the Healing Arts*, 916 S.W.2d 311 (Mo.App. E.D. 1995). Therein, the court reversed the decision of the Board of Healing Arts to suspend Dr. Boyd's license for practicing without a license, for approximately two (2) months before she received her Missouri license. Although the Commission found cause for the Board to discipline Dr. Boyd's license, the court concluded, after considering the circumstances of the case, that the six (6) month suspension of Dr. Boyd's license was not justified and was not supported by substantial and competent evidence. *See* 916 S.W.2d at 317. In arriving at this conclusion, the court reviewed the testimony of four (4) character witnesses offered by Dr. Boyd. Thereafter, the court reversed the Board's decision to suspend Dr. Boyd's license and remanded the case to the Board to impose probation. *See* 916 S.W.2d at 318.

Dr. Tendai, like Dr. Boyd and Dr. Gard, offered extensive evidence of his good character and standing in the community. As noted above, several physicians from the Springfield area wrote recommendations in support of Dr. Tendai. Of particular interest,

is an Affidavit written by Dr. Darrell Domann, a former member of the Missouri State Board of Registration for the Healing Arts.

In addition, Dr. Tendai offered evidence of eighty (80) cases demonstrating exactly what type of discipline the Board has rendered under similar cases. The Board, without explanation, ignored all of this evidence and elected to punish Dr. Tendai by suspending his license and permanently prohibiting him from practicing obstetrics. The Board's decision was clearly not supported by competent and substantial evidence and was an abuse of discretion. This Court should, therefore, as in *Gard* and *Boyd*, reverse the imposition of the Board's suspension of Dr. Tendai's license and the restriction which prohibits Dr. Tendai from practicing obstetrics.

D. The Board acted unlawfully in closing its disciplinary deliberations for discussion of "public business", in violation of Chapter 610, RSMo.

The Board's disciplinary hearing was conducted on April 28, 2000. L.F. 01122-92. Upon conclusion of the hearing and after both parties had presented evidence, the Board's President stated that the Board would issue its order "when it's [sic] completed its deliberations and a copy of the order will be mailed to the doctor and his attorney." L.F. 01190. The Board refused a request by Dr. Tendai that disciplinary deliberations be opened to allow he and his counsel to attend and participate in the deliberations. L.F. 01190-91. The Board then adjourned formal proceedings without having reached its disciplinary determination. *Id*. Dr. Tendai's alternative request, that the Board postpone its deliberations until the resolution of pending appellate cases involving the propriety of

closed Board deliberations, was also denied. *Id*. The Board's ultimate "Findings of Fact, Conclusions of Law and Order" (issued May 15, 2000; L.F. 01935-39) was a product of the Board's closed deliberations following conclusion of the hearing, and was reached with no further attendance or participation by Dr. Tendai or his legal counsel.

Dr. Tendai is asking this Court to review the legality of the Board's action in applying provisions of Chapter 610, RSMo. (a/k/a the "Sunshine Law") to close its disciplinary deliberations regarding his license. As such, this Court may exercise its independent judgment in reviewing the Board's interpretation and application of the Sunshine Law in this case. *See Doe Run Resource Co. v. Director of Revenue*, 982 S.W.2d 269 (Mo. banc 1998).

"Chapter 610 embodies Missouri's commitment to open government and is to be construed liberally in favor of open government." *North Kansas City Hosp. Bd. Of Trustees v. St. Luke's Northland Hospital*, 984 S.W.2d 113, 119 (Mo. App. W.D. 1998). The purpose of the Sunshine Law is "to open official conduct to the scrutiny of the electorate." *North Kansas City* at 122, citing *Hyde v. City of Columbia*, 637 S.W.2d 251, 262 (Mo. App. W.D. 1982). While there are certain exceptions contained within Chapter 610 allowing "public governmental bodies" to close their meetings and other activities to the public, these exceptions are to be strictly construed so as to promote the public policy that meetings, records, votes, actions, and <u>deliberations</u> of public governmental bodies be

open to the public.[25] Section 610.011.1, RSMo.; *North Kansas City Hospital*, 984 S.W. 2d at 119.

Chapter 610 defines "public meeting" as "any meeting of a public governmental body subject to sections 610.010 to 610.030 at which any public business is discussed, decided, or public policy formulated, whether corporeal or by means of communication equipment. . .". *See* §610.010(5), RSMo. Section 610.010(3) defines "public business" as "all matters which relate in any way to the performance of the public governmental body's functions or the conduct of its business." Pursuant to §334.100, RSMo., and in light of Chapter 334 itself being a remedial act enacted for the welfare of the public,[26] this Court is compelled to conclude that the Board's meeting to conduct Dr. Tendai's disciplinary hearing, during which it received evidence, deliberated, and voted concerning the discipline to be imposed upon Dr. Tendai's license, was a meeting at which "public business" was conducted.

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[25] Unquestionably, the Board is a "public governmental body" to which the provisions of the Sunshine Law apply. Section 610.010 (4) RSMo. defines this term as "any legislative, administrative governmental entity created by the constitution or statutes of this state, ***", to specifically include "[a]ny. . .board. . .which is supported in whole or in part from state funds."

[26] *See Bhuket v. State Bd. of Registration for the Healing Arts*, 787 S.W.2d 882, 885 (Mo. App. W.D. 1990).

Pursuant to 610.022, RSMo., "an affirmative public vote of the majority of a quorum of a public governmental body" must be taken prior to the governmental body closing a meeting or vote to the public. Further, the agency must state publicly, and record in its minutes, "the specific reason for closing that meeting or vote by reference to a specific section of [Chapter 610]. . ." Section 610.022(1), RSMo. *See also Spradlin v. City of Fulton*, 982 S.W.2d 255 (Mo. banc 1998). Finally, §610.022(2) requires that an agency proposing to conduct a closed meeting or vote "shall give notice of the time, date and place of such closed meeting or vote and the reason for holding it by reference to the specific exception allowed [under Chapter 610.021 RSMo.]. . ."

The Board failed to follow the requirements of Chapter 610 regarding its closed deliberations to discuss Dr. Tendai's discipline. As shown above, this decision was clearly a matter of "public business," yet the Board did not: a) provide or attempt to provide the notice required by §610.022, RSMo.; b) take a vote of a majority of its quorum to close its meeting for disciplinary deliberations, as required by §610.022; or c) state publicly or in its minutes its reason, with reference to a specific statutory provision, for closing its deliberations to the public, as also required by §610.022. The specific request by counsel for Dr. Tendai that the deliberations be conducted in an open meeting was flatly denied by the Board's President. L.F. 01190-91.

Finally, the Board, although possibly acting in a "quasi-judicial capacity" when conducting the disciplinary hearing and deliberations concerning Dr. Tendai, is not tantamount to a court; therefore, its deliberations are subject to the open meeting

requirements of the Sunshine Law. *Remington v. City of Boonville*, 701 S.W.2d 804, 805 (Mo. App. W.D. 1985). The Board may thus not avail itself of exceptions within the Sunshine Law applicable to certain judicial activities. 701 S.W.2d at 807.

Section 610.027, RSMo. grants this Court the ability to invalidate actions taken by the Board which are in violation of the Sunshine Law, if "the public interest in enforcement of the policy [of the Sunshine Law] outweighs the public interest in sustaining the validity of the action taken in the closed meeting. . ." Section 610.027.4, RSMo. The circumstances of this case weigh heavily in favor of upholding the policy behind the Sunshine Law, and holding the Board accountable for its violations of that law. This conclusion is amply supported by the evidence upon the whole record, which reveals that Dr. Tendai is an exemplary physician and citizen with a long record of service to the patients and facilities he has served, and whose absence from the Missouri health care community would certainly do more violence to the public interest than his continued presence in that community.[27] There is, in fact, no public interest advanced by result of the discipline ordered by the Board, and a significant public interest in enforcement of the Sunshine Law to require the Board's future compliance in similar matters. For these reasons (and others herein) the Board's "Findings of Fact,

[27] *See* additional discussion under part C of this Point V.

Conclusions of Law and Order" must be invalidated by this Court, pursuant to Missouri law and public policy.[28]

The Board further denied Dr. Tendai the right to a fair trial by excluding Dr. Tendai and his attorney from the deliberations, while allowing unnecessary employees of the Board to remain in the hearing. *Furthermore, such action constitutes a waiver by the Board of its right, if any, to conduct a closed hearing.*

As previously discussed, the Board excluded Dr. Tendai and his attorney from the deliberations, but allowed eleven (11) to fourteen (14) persons, in addition to the members of the Board to attend those deliberations. L.F. 01975. Allowing those persons to attend the deliberations is inconsistent with a closed meeting and denied Dr. Tendai a right to a fair hearing. Furthermore, allowing persons other than members of the Board to participate in the closed deliberations constitutes a waiver by the Board of its right, if any, to close those deliberations. Dr. Tendai should not have been excluded from these deliberations.

[28] In addition to violating provisions of Chapter 610, RSMo., the Board's failure to preserve a record of its closed deliberations is in violation of Section 536.070(4), which requires that "[e]ach agency shall cause all proceedings in hearings before it to be suitably recorded and preserved." *See Application of 354 Skinker Corp*., 622 S.W.2d 724 (Mo. App. E.D. 1981). The Board created no record of its closed deliberations concerning Dr. Tendai's license. L.F. 01976.

E. §334.100.2 establishes a procedure for determining physician competency.

Section 334.100.2 contains two separate provisions under which a physician may be found incompetent. Section 334.100.2(5), (under which the Commission found Dr. Tendai's license subject to discipline) provides that a complaint may be brought against a physician for "incompetency." Section 334.100.2(25) states that a complaint may be brought against a physician based upon "medical or osteopathic incompetency." As with subdivision (5), there is no definition of incompetency within subdivision (25) nor anywhere else in Chapter 334. Section 334.100.2(25)(a) states the statutory qualification for proof of competency as follows:

> ". . .[i]n enforcing this subdivision the board shall, after a hearing by the board, upon a finding of probable cause, require a physician to submit to a reexamination *for the purpose of establishing his or her competency to practice as a physician or surgeon* or with a specialty conducted in accordance with rules adopted for this purpose by the board. . .".

(Emphasis added). Section 334.100.2(25)(d) further states as follows:

> ". . .[a] physician whose right to practice has been affected under this subdivision shall, at regular intervals, be afforded the opportunity to demonstrate that the physician can resume the competent practice as a physician or surgeon with reasonable skill and safety to patients."

The Board has also promulgated its rule 4 CSR 150-2.150, which provides in relevant part:

> "The board may require each applicant seeking to restore to good standing a license. . .issued under Chapter 334, RSMo., which has been revoked, suspended or inactive for any reason for more than two years, to present with his/her application evidence to establish the following: [s]atisfactorily completing twenty-five (25) hours of continuing medical education for each year during which the license was revoked, suspended or inactive; and [s]uccessfully passing, during the revoked, suspended or inactive period. . .the American Specialty Board's certifying examination in the physician's field of specialization, Component 2 of the Federation Licensing Examination (FLEX) before January 1, 1994, Step 3 of the United States Medical Licensing Examination (USMLE) or the Federation of State Medical Board's Special Purpose Examination (SPEX)."

This rule provides the sole methodology to prove competence and restore a suspended or revoked license. Therefore, a physician who has passed a specialty board examination, or one of the other examinations referenced in the rule, is deemed competent under §334.100.2(25)(a) and 4 CSR 150-2.150. Because there are no definitions of "incompetence" within either subdivision (5) or (25) of §334.100.2, then it must be concluded that such a physician has proven his competence under subdivision (5) as well.

Despite these procedures, the Board has taken no action to determine Dr. Tendai's competence under the procedures established in §334.100.2(25) or 4 CSR 150-2.150. The Board, however, is bound by the terms of rules it has promulgated. *See Berry v. Moorman Mfg. Co.*, 675 S.W.2d 131, 134 (Mo. App. W.D.1984). Furthermore, the Board's failure to comply with its own rule may invalidate its actions when prejudice results. *Missouri Nat. Educ. Ass'n. v. Missouri State Bd. of Mediation*, 695 S.W.2d 894, 897 (Mo. banc 1985). Dr. Tendai has clearly been prejudiced by the Board's failure to allow him to prove his competence pursuant to the Board's statutory and regulatory procedures. Therefore, the Board's disciplinary order must be reversed inasmuch as it is premised upon a conclusion that Dr. Tendai's conduct, with respect to S. G., was incompetent.

F. The Board failed to observe statutory procedural requirements.

Chapter 536, RSMo. sets forth numerous procedural requirements to be followed by an agency prosecuting a "contested case[29]." In initiating its disciplinary proceedings against Dr. Tendai, the Board failed to observe these requirements in the ways which are touched on briefly below.

[29] "Contested case" is defined as "a proceeding before an agency in which legal rights, duties or privileges of specific parties are required by law to be determined after hearing[.]" Section 536.010(2), RSMo. In that there is no dispute that the Board is an "agency" under Chapter 536, and that its disciplinary action against Dr. Tendai is a "contested case", no further argument on these issues is included herein.

"Due process is provided by affording parties to an administrative proceeding the opportunity to be heard at a meaningful time and in a meaningful manner. . .[i]t requires that a litigant have knowledge of the claims of his or her opponent, have a full opportunity to be heard, and to defend, enforce and protect his or her rights." *Brawley & Flowers, Inc. v. Gunter*, 934 S.W.2d 557, 560 (Mo. App. S.D. 1996); citing *In re S___ M___ W___*, 485 S.W.2d 158, 163 (Mo. App. 1972). Further, "[t]he procedural due process requirement of fair trials by fair tribunals applies to administrative agencies acting in an adjudicative capacity." *Wagner v. Jackson County Bd. of Zoning Adjustment*, 857 S.W.2d 285, 289 (Mo. App. W.D. 1993); citing *Fitzgerald v. City of Maryland Heights*, 796 S.W.2d 52, 59 (Mo. App. E.D. 1990).

Section 536.063, RSMo., provides that in any contested case:

> **The contested case shall be commenced by the filing of a writing by which the party or agency instituting the proceedings seeks such action as by law can be taken by the agency** only after opportunity for hearing, or seeks a hearing for the purpose of obtaining a decision reviewable upon the record of the proceedings and evidence at such hearing, or upon such record and additional evidence, either by a court or by another agency. * * *
>
> **Any writing filed whereby affirmative relief is sought shall state what relief is sought or proposed and the reason for granting it, and shall not**

> **consist merely of statements or charges phrased in the language of a statute or rule**[.]

Section 536.063(1)-(2) RSMo. (emphasis added).

Despite these clear requirements, the Board failed to file any writing in compliance with §536.063, when instituting its disciplinary proceedings against Dr. Tendai. The only "writings" filed by the Board were its notices of disciplinary hearing, which are identical but for the dates of hearing contained therein. L.F. 01056-58; 01110. None of these notices set forth "what relief is sought or proposed," and merely recite statements from various statutory provisions. *Id*.

Further, §536.067, RSMo. contains additional requirements relative to the notice required to be given in a contested case. Among other requirements, this section provides that such notice must state in substance:

> **That a writing seeking relief has been filed in such case, the date it was filed, and the name of the party filing the same* * *[a] brief statement of the matter involved in the case unless a copy of the writing accompanies said notice* * *[w]hether an answer to the writing is required, and if so the date when it must be filed* * *[t]hat a copy of the writing may be obtained from the agency, giving the address to which application for such a copy may be made. This may be omitted if the notice is accompanied by a copy of such writing[.]**

Section 536.067 (2), RSMo. (emphasis added). Clearly, this language compels the conclusion that the "notice" described therein is separate and distinct from the "writing" (i.e., complaint) referenced in §536.063 RSMo. The Board's notices, however, fail even to comply with the requirements for such notices as set forth in §536.067, much less provide the information required of the "writing" dictated by §536.063.

In administrative proceedings, notice and an opportunity to be heard must be provided by the state in meaningful manner prior to the deprivation of a protected interest. *State ex rel. Williams v. Marsh*, 626 S.W.2d 223, 230 (Mo. banc 1982). A physician has a property interest in his or her license to practice medicine, and must be provided with due process of law before that license may be revoked. *Larocca v. State Bd. of Registration for the Healing Arts*, 897 S.W.2d 37, 42 (Mo.App. E.D. 1995). The Board's failure to comply with §§536.063 and 536.067, in the ways discussed above, impaired Dr. Tendai's ability to identify (let alone defend against) any disciplinary action which the Board sought to impose in its disciplinary proceedings. Therefore, Dr. Tendai did not receive meaningful notice and was accordingly denied a fair opportunity to defend his medical license in the Board's proceedings. In turn, Dr. Tendai was denied procedural due process, a result which could easily have been avoided had the Board merely followed the requirements of Chapter 536, RSMo. applicable to such agency action.

CONCLUSION

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

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the above and foregoing document and one copy of the disk required under Rule 84.06(c) were served this 22nd day of October, 2004, by either U.S. Mail, postage prepaid, or hand-delivery to the following: Mr. Glenn Bradford, 1150 Grand Avenue, Suite 230, Kansas City, Missouri 64104 and Ms. Jane Rackers, Missouri Office of the Attorney General, P.O. Box 899, Jefferson City, MO 65102.

CERTIFICATE OF COMPLIANCE

Pursuant to Missouri Supreme Court Rule 84.06(c), 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 Microsoft Office Word 2003, the entire brief contains 30,018 words. Respondent further certifies that, pursuant to Rule 84.06(c), it is filing with this brief a computer disk which contains a copy of the above and foregoing brief, which was prepared using Microsoft Office Word 2003, and Respondent also certifies that the disk has been scanned for viruses and is virus-free.

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