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

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

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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

POINT I

I. THE ADMINISTRATIVE HEARING COMMISSION ("COMMISSION") ERRED IN ITS DECISION THAT DR. TENDAI'S MEDICAL LICENSE IS SUBJECT TO DISCIPLINE FOR INCOMPETENCY, GROSS NEGLIGENCE, CONDUCT HARMFUL TO A PATIENT, AND REPEATED NEGLIGENCE BECAUSE SECTION 334.100.2(5)

RSMO. IS UNCONSTITUTIONALLY VAGUE AND, AS APPLIED BY THE COMMISSION, VIOLATES DR. TENDAI'S RIGHTS TO PROCEDURAL DUE PROCESS IN THAT THESE TERMS ARE UNDEFINED OR INADEQUATELY DEFINED, ARE NOT TERMS OF GENERAL KNOWLEDGE OR UNDERSTANDING, AND PROVIDED DR. TENDAI WITH NO OBJECTIVE GUIDELINES OR STANDARDS FOR AVOIDING THE PROHIBITED CONDUCT AS DETERMINED BY THE COMMISSION.

The Board of Healing Arts ("Board") erroneously cites *State of Missouri, ex rel., Hurwitz v. North*, 271 U.S. 40, 46 S.Ct. 384, 385, 70 L.Ed. 818 (1926) for the proposition that the United States Supreme Court held early on that Section 334.100.2(5) "is not generally a denial of equal protection of the laws or due process. Board Brief at 20. In *Hurwitz*, the Court reviewed Section 7336, Mo. Rev. Stat. (1919) (which bears little resemblance to Section 334.100.2(5)) and concluded that a physician who performed a criminal abortion, which was specifically prescribed by the statute, was not denied procedural due process or equal protection simply because the Board of Health was not authorized by statute to subpoena witnesses to appear before the Board of Health. *Hurwitz*, 271 U.S. at 42-43. The Court found that the physician received adequate notice of the hearing, was authorized to present live testimony or testimony of witnesses taken by deposition. *Id*. at 42. Furthermore, even though the Board of Health was not authorized to subpoena witnesses, the physician could have compelled witnesses to testify by deposition. *Id*. at 42. Consequently, under the circumstances presented in that case, where the physician had violated a specific prohibition

against performing a criminal abortion, the Court concluded that Missouri's statute did not deny that physician procedural due process or equal protection. *Id*. at 42-43. The Court did not address any claim that the statute was void for vagueness. Consequently, *Hurwitz* does not provide any guidance on the issues presented by Dr. Tendai.

Under this point the Board also argues that the holding in *Dorman v. State Bd. Of Registration for the Healing Arts***,** 62 S.W.3d 446(Mo. App. W.D. 2001), supports the Commission's conclusion that Dr. Tendai acted with "repeated negligence" in his treatment of Miss S.G. For the reasons detailed in Point II(C) herein, the *Dorman* case is inapposite to the present facts and is therefore unpersuasive as precedent for the Commission's flawed conclusion on this issue.

POINT II

II. THE ADMINISTRATIVE HEARING COMMISSION ("COMMISSION") ERRED IN ITS DECISION THAT DR. TENDAI'S LICENSE IS SUBJECT TO DISCIPLINE FOR INCOMPETENCY, GROSS NEGLIGENCE, CONDUCT HARMFUL TO A PATIENT, AND REPEATED NEGLIGENCE BECAUSE THOSE LEGAL CONCLUSIONS ARE UNAUTHORIZED BY LAW; ARE ARBITRARY, CAPRICIOUS AND UNREASONABLE; INVOLVE AN ABUSE OF DISCRETION; AND ARE UNSUPPORTED BY COMPETENT AND SUBSTANTIAL EVIDENCE ON THE WHOLE RECORD: (A) IN THAT THE BOARD FAILED TO CARRY ITS BURDEN OF ESTABLISHING A STANDARD OF CARE FOR PHYSICIANS NOT HAVING AVAILABLE TO THEM A MEDICALLY APPROPRIATE REFERRAL ALTERNATIVE;

(B) IN THAT THE COMMISSION'S LEGAL CONCLUSION THAT DR. TENDAI IS SUBJECT TO DISCIPLINE FOR NOT REFERRING MISS S.G. TO A PERINATOLOGIST IS ERRONEOUS IN LIGHT OF THE COMMISSION'S FINDING OF FACT THAT DR. TENDAI DID NOT REFER MISS 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 MISS 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 MISS S.G. TO A PERINATOLOGIST.

The Board mischaracterizes Dr. Tendai's argument, claiming that Dr. Tendai's basic argument "is that the Administrative Hearing Commission incorrectly accepted the Board's evidence as credible, as against his own . . . testimony." Board Brief at 20. Nothing could be further from the truth. Point II of Dr. Tendai's argument points out five different errors. Only one of those five errors, presented under Point II (E), attacks the Commission's acceptance of Miss S.G.'s testimony over that of Dr. Tendai. All of the other portions of Point II of Dr.

Tendai's argument accept, *arguendo*, the Commission's acceptance of Miss S.G.'s testimony over Dr. Tendai's testimony. Consequently, none of the first four arguments under Point II of Dr. Tendai's Brief require this Court to consider the Commission's erroneous factual findings. Rather, they are focused purely on the Commission's erroneous legal conclusions, which this Court reviews *de novo*. *Concord Pub. House, Inc. v. Director of Revenue*, 916 S.W.2d 186, 189 (Mo. banc 1996).

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

(B) THE COMMISSION'S LEGAL CONCLUSION THAT DR. TENDAI IS SUBJECT TO DISCIPLINE FOR NOT REFERRING MISS S.G. TO A PERINATOLOGIST IS ERRONEOUS IN LIGHT OF THE COMMISSION'S FINDING OF FACT THAT DR. TENDAI DID NOT REFER MISS 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.

The Board cites no facts and no cases to defend the Commission's flawed decision in response to this portion of Dr. Tendai's argument. The Board cannot escape the fact that it bears the burden of proving the standard of care and Dr. Tendai's violation of the standard of

care. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo.App.W.D. 1992); *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo.App.W.D. 1989). Quite simply, there was no expert testimony concerning the appropriate standard of care under the circumstances in this case because the testimony which the Commission adopted to support its finding that Dr. Tendai did not refer Miss 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 was not presented until rebuttal. That is when the Board's witness, who had observed the entire trial, offered his testimony. L.F. 00502-511. Dr. Tendai's expert witness, Dr. Griffin, who had already testified and been excused, was not asked to opine as to the standard of care under those circumstances. The Board's expert, Dr. Cameron, had given his opinion in a deposition taken one year before the hearing, and his testimony contained no opinion concerning a standard of care under those circumstances. Consequently, the Board failed to meet its burden of proof.

Had the Board not sandbagged Dr. Tendai and waited until rebuttal to tender the testimony of its investigator Brian Hutchings, then Dr. Tendai's expert witness could have offered an expert opinion concerning the standard of care under those circumstances. Further, the Board could have asked its expert witness a hypothetical question during his deposition, or asked him to testify at the hearing. However, the Board did neither. Inasmuch as the Board did not tender any evidence to support the Commission's critical finding as to the circumstances confronting Dr. Tendai until rebuttal, the Board is hardly in a position to complain that it "ought not . . . be required to present expert testimony negating every excuse Dr. Tendai is able to

come up with to justify his failure to do the required testing or to make a referral to a physician who would." Board Brief at 58. The Board waited until rebuttal to offer the testimony which the Commission accepted as the controlling circumstances in this case. The Board bears the burden of proof and the Board failed to establish the standard of care (let alone a violation of the standard of care) based on the circumstances that the Commission found to exist. Consequently, the Commission Decision, and the Disciplinary Order of the Board which is premised upon the Commission Decision, should be reversed.

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

The Board cited to *Dorman v. State Bd. Of Registration for the Healing Arts***,** 62 S.W.3d 446 (Mo. App. W.D. 2001), to support the Commission's misguided conclusion that Dr. Tendai is subject to discipline for repeated negligence based upon his continuous course of treatment of Miss S.G. on November 9, November 16 and November 23, 1992.[1] *Dorman*

[1] The Board apparently mistakenly included a reference to negligence on November 2, 1992, at page 29 of the Board's Brief. The Commission specifically found that Dr. Tendai suspected IUGR on November 2, 1992, and sent Miss G. to Cox Hospital for a follow up ultrasound examination on that date to confirm that finding. There was no testimony before or finding by the Commission that Dr. Tendai's treatment of Miss G. through November 2, 1992, deviated from the standard of care.

does affirm the Commission's finding of repeated negligence. However, the court did not address the issue presented to this Court - that repeated negligence may not lie against a physician for the same omission concerning one obstetric patient during a continuous course of treatment. To the contrary, the Commission found nine different shortcomings by Dr. Dorman to support its conclusion that Dr. Dorman was repeatedly negligent. Specifically:

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

Dorman, at 62 S.W.3d at 452-53. Consequently, *Dorman* does not support discipline against Dr. Tendai for repeated negligence in his continuous course of care of one obstetric patient during three visits over a fifteen-day period.

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

With the exception of one paragraph, the Board ignores this portion of Dr. Tendai's Brief. The Board's claim that it "adequately pleaded that Dr. Tendai was guilty of 'repeated negligence' in his treatment of Patient S.G." is completely unsubstantiated. Board Brief at p. 30. Count III of the pleading speaks for itself, and it does not allege that Dr. Tendai's treatment of Miss S.G. constituted repeated negligence. L.F. 00018-19. Consequently, the Commission granted relief not requested by the pleadings, exceeding its authority and abusing its discretion. *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo.App.E.D. 1984) *Duncan v. Bd. for Architects, Professional Eng'rs. and Land Surveyors*, 744 S.W.2d 524, 538-39 (Mo. App. E.D. 1988). Therefore, the Commission's conclusion that Dr. Tendai was subject to discipline for repeated negligence must be reversed.

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

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

In its Brief the Board would appear to suggest that this Court cannot, under any circumstance, question the determinations made by the Commission concerning witness credibility. This is inaccurate. As pointed out in Dr. Tendai's Appellant's Brief, 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). As demonstrated below, there were numerous inconsistencies in Miss S.G.'s testimony as to key events, rendering her credibility highly suspect.

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

Miss S.G. contradicted her direct testimony with the following admissions during cross-examination:

1. Miss S.G. admitted that Dr. Tendai told her, during the October 16, 1992 visit, that her baby was small. L.F. 00640, Line 19.

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

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

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

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

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

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

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

to come in more frequently than every two weeks. L.F. 00586, Lines 1-7. Dr. Tendai's records clearly reflect, however, that he saw her weekly, from November 2, 1992, through November 23, 1992. L.F. 00802. While the Commission found that Dr. Tendai saw Miss S.G. on November 2, November 9, November 16 and November 23, it neglected to notice Miss S.G.'s false testimony wherein she claimed that Dr. Tendai never asked her to come in more often than every two weeks.

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

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

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

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

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

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

The Board groundlessly claims that the Commission took the expert testimony of Dr. James Johnson for what it was worth. Board Brief at pp. 68-71. That contention is completely unsubstantiated, inasmuch as the Commission Decision failed to mention Dr. Johnson's testimony. The Board also claims that Dr. Johnson simply accepted Dr. Tendai's statements as to what happened to Miss S.G. at face value, and that Dr. Johnson was unaware of Miss S.G.'s versions of the events. Board Brief at pp. 69-70. Obviously, the converse is also true for the Board's expert, Dr. Cameron, whose testimony was taken one year before the hearing and which did not consider Dr. Tendai's version of the events. L.F. 00514, 00563.

Not surprisingly, the Board does not address the critical directive of *Mineweld, Inc. v. Board of Boiler and Pressure Vessel Rules,* 868 S.W.2d 232, 234 (Mo.App., W.D. 1994), which establishes that a trier of fact may not ignore or arbitrarily disregard evidence without explanation. That is precisely what the Commission did with the expert testimony of Dr. Johnson. The Commission's failure to consider this evidence is an abuse of discretion, arbitrary, capricious and unreasonable. Therefore, the Commission Decision must be reversed. *Psychare Management, Inc. v. Department of Social Services,* 980 S.W.2d 311, 312 (Mo. banc 1998).

Finally, the Board devotes significant attention to the "at war" doctrine, in an attempt to show that Dr. Tendai has argued two inconsistent and divergent defenses. *See*, Board Brief at pp. 58-61. However, if either party to this matter is culpable of violating the "at war" doctrine, it is the Board. By virtue of introducing in rebuttal testimony (i.e. via Board investigator Brian K. Hutchings) its position that Dr. Tendai failed to refer Miss S.G. to a perinatologist because he was afraid the perinatologist would deliver the baby too soon, the Board thereby posed a theory contrary to its pleadings and case-in-chief. Of course, it is this theory which was adopted by the Commission in its decision. In addition, the cases cited by the Board all obviously relate to plaintiffs before juries in civil cases; none of these cases apply the "at war" doctrine to a professional licensee defending himself in an administrative proceeding.

POINT III

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

The Board's argument under this Point III essentially boils down to the following: since the Commission implied that Dr. Tendai created phony evidence, he necessarily lied under oath, which allows the Board of Healing Arts to impose any discipline it selects. Board Brief at pp. 73-74. Furthermore, since Dr. Tendai had voluntarily limited his practice to gynecology, the Board's order permanently prohibiting him from practicing obstetrics did not harm him. Board's Brief at 72.

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

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

The Board claims that it was justified in imposing any discipline it selected due to the presence of mendacity. However, the Board continues to demonstrate that it took that factor into consideration. Certainly, there is no such finding in its Disciplinary Order. As illustrated in the statement of facts in Dr. Tendai's Initial Brief, at pages 42-43, there are no findings whatsoever in the Disciplinary Order to explain why the Board imposed the chosen discipline. If the Board believed that Dr. Tendai falsified records, then why didn't the Board plead that violation of the Healing Arts Practice Act and seek findings and conclusions from the Commission on that violation? Furthermore, if the Board believed that Dr. Tendai falsified records, then why would it order Dr. Tendai to attend a course on medical records wherein physicians are instructed to keep more detailed records and practice defensive medicine. Finally, if the Board truly believed that Dr. Tendai was lying to protect himself and had simply let this patient's child die, then why didn't it revoke his license? We do not know, because the Board made no finding to justify its discipline.

POINT IV

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.

To support the Circuit Court's Judgment of June 1, 2004, ("Judgment") in which the Circuit Court denied Dr. Tendai's equal protection claims based on numerous similar cases in which the Board had imposed less discipline, the Board argues rather summarily that Dr. Tendai lost on this issue because he failed to prove that "he was intentionally treated differently from other [sic] similarly situated and that there was no rational basis for the difference in treatment", citing *Village of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000).

Obviously, Dr. Tendai disagrees with the Board's conclusion, and the Judgment, concerning the implications of the *Olech* opinion, and has set forth his detailed argument as to this issue in his Initial Brief at pp. 104-109. Dr. Tendai believes that the Circuit Court misapplied the disparate treatment analysis prescribed by the U.S. Supreme Court in *Olech*, and would refer this Court to his Initial Brief concerning this issue. Therein, Dr. Tendai details why the Circuit Court erred in distinguishing the over eighty (80) cases submitted in evidence

before the Board in which less discipline was ordered in cases involving very similar conduct. *See* Appellant's Brief, pp. 90-95.

Further, in his Initial Brief Dr. Tendai explains why the Board has failed to show any rational basis for its disparate treatment of Dr. Tendai, as compared with those numerous previous similar cases. *See* Appellant's Brief, pp. 104-109.

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

POINT V

V. THE BOARD OF HEALING ARTS ("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.

The Board's response raised to the issues in this Point[2] is somewhat puzzling, in that it fails to address the Board's fundamental and complete failure to issue a disciplinary decision which complied with the minimum standards for such a decision, as set forth in the *Heinen* and *Weber* opinions (*see* Dr. Tendai's discussion of these cases at pp. 110-113 of Appellant's Brief). Rather, the Board spends nearly four pages of its Brief discussing the procedural and notice requirements attendant to the Board's disciplinary hearing (Board Brief at pp. 80-83),

[2]The issues raised by Dr. Tendai in Point V of his Appellant's Brief were addressed by the Board in Point IV of its Brief. For consistency, Dr. Tendai has organized this Reply Brief under the same Points as set forth in his initial Brief.

this in spite of the fact that Dr. Tendai has not challenged the issue of notice before this Court.

Perhaps the Board's lack of any answer for the deficiencies in its Disciplinary Order account for its misplaced focus; however, Dr. Tendai would suggest that the Board has, by its failure to respond, essentially conceded the issue of the legal deficiencies in its Disciplinary Order, as thoroughly addressed in Dr. Tendai's Appellant's Brief.

In any case, it is clear that the mandates of cases such as *Heinen* and *Weber* are applicable to the written disciplinary decisions of professional licensing agencies, certainly to include the Board. Section 621.110, RSMo. 1994, does not exempt the Board from issuing a Disciplinary Order which contains a factual basis for the disciplinary determination rendered against Dr. Tendai.

The Board also argues that a statutory amendment, contained in Sec. 620.010.14(8), RSMo. Supp. 2003, effectively moots Dr. Tendai's argument that the Board erred in closing its disciplinary deliberations. *See*, Board Brief at pp. 83-84. However, this statutory amendment (closing the deliberations of licensing agencies under Chapter 620, RSMo.) is <u>not</u>, of course, an amendment to Chapter 610, RSMo. (a/k/a the Sunshine Law) itself, and there is no suggestion in that amendment that the legislature intended to deny open deliberations to those licensees whose disciplinary hearings came up <u>before</u> the amendment was made. Accordingly, the Board's argument on this issue has no merit.

CONCLUSION

For any or all of the above-stated reasons, the Commission Decision, the Board's Disciplinary Order, and the 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 two true and correct copies of the above and foregoing document and one copy of the disk required under Rule 84.06(c) were served this 21st day of December, 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.

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CERTIFICATE OF COMPLIANCE

Pursuant to Missouri Supreme Court Rule 84.06(c), Respondent hereby certifies that this brief complies with the limitations contained in Rule 84.06(c) and that, according to the word count feature in Microsoft Office Word 2003, the entire brief, excluding the cover, contains 7,049 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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