The Regulation and Discipline of Physicians in Missouri

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I. Introduction

Missouri’s statutory scheme for the discipline of physicians is complex. The Missouri State Board of Registration for the Healing Arts has wide-ranging discretion that, except for physician competency hearings, is subject to Administrative Hearing Commission (AHC) review to hear evidence and decide whether the facts support the board’s charges. If the AHC finds that the charges are supported, the board imposes discipline. AHC and board decisions, in turn, are subject to judicial review.

This article will provide an overview of the statutory scheme and its case law interpretation, as well as provide principles for responding to disciplinary actions.

II. Statutory Scheme

A. Grounds for Discipline

The grounds for discipline are many and varied. The Revised Statutes of Missouri § 334.100.2 provides the primary statutory authority for physician discipline, setting forth more than 40 separate causes, some of which are: 1) “[u]se of any controlled substance[s]” or alcoholic beverages such that they impair one’s ability to perform work; 2) a judicial finding of guilt for an “offense reasonably related to the qualifications, functions or duties of any profession licensed[;]” 3) obtaining a fee by fraud or willful “overcharging or overtreating patients;” 4) “performing an inappropriate or unnecessary treatment;” 5) “[d]elegating professional responsibilities” to unqualified persons; 6) a “[f]inal disciplinary action by any professional medical or osteopathic association . . . or licensed hospital or medical staff . . . in this or any other state” if “related to unprofessional conduct, professional incompetence, malpractice or other violation[s]” of this chapter; 7) “[s]igning a blank prescription form; or dispensing” a controlled substance.
B. Board Procedure for Disciplining Currently Licensed Physicians

The board’s rules and regulations are set out in the Code of State Regulations (CSR).6 Complaints against physicians can come from “member[s] of the public or the profession, or any federal, state or local official.”7 The Missouri Department of Insurance must provide reports of claims of medical malpractice.8 “[E]xecutive officers of hospitals and ambulatory surgical centers” must report “disciplinary actions and voluntary resignations.”9

Generally, complaints or reports of medical malpractice claims or of disciplinary actions are logged in and delivered to the board’s medical staff officer, who, after review, either issues a request for investigation or forwards it to the disciplinary committee with recommendations. If investigation is requested, a file is opened and an investigator is assigned who, upon completing the investigation, submits a written report to the investigative coordinator. The investigative coordinator, in turn, submits a report to the medical consultant. The medical consultant delivers the report and recommendation to the disciplinary committee, which submits the report and recommendation to the board. Throughout the investigation process the reports and recommendations can be returned for further review or investigation. Ultimately, the board may close the investigation or initiate proceedings by filing a complaint with the AHC.10 Similarly, physicians may file AHC claims against the board, such as when a license is denied.11

C. The AHC

Procedures applicable to the AHC are also set forth in the CSR.12 Complaints must be in writing.13 Respondents must file answers.14 Intervention is allowed.15 Discovery may be obtained.16 Sanctions are available.17 There is a motion practice.18 Hearings are conducted,19 generally in Jefferson City.20 Videoconferencing may be requested.21 At the hearing, oral evidence is upon oath or affirmation.22 The rules of evidence are relaxed;23 “although technical rules of evidence are not controlling . . ., fundamental rules of evidence” apply.24 Parties may call or cross-examine witnesses, introduce exhibits and rebut evidence.25 There is no right to disqualify a commissioner.26 AHC decisions must be in writing and contain separately stated findings of fact and conclusions of law;27 unless the parties waive the requirement, in which event the case may be decided by a bench ruling or a memorandum decision setting forth the ultimate disposition.28

The AHC’s task is to make findings on the cause’s charges “for which [a] license may be suspended or revoked,”29 or for which the license has been denied.30

If the AHC “fails to find any cause charged” by the board, the AHC dismisses the complaint and notifies the parties.31 On the other hand, if the AHC finds any cause charged, it may make non-binding recommendations to the board as to appropriate discipline.32 Attorney’s fees are available to a physician who prevails in an AHC proceeding.33

and federal agencies; 14) adjudicated incapacitated or disabled; 15) obtaining a certificate of registration “based upon a material mistake of fact;” 16) “[v]iolation of the drug laws or rules” of any state; and 17) “[a] pattern of personal use or consumption of a controlled substance unless [properly] prescribed” and dispensed by another physician.

“without sufficient examination;” 8) use of “physician-patient relationship for purposes of engaging a patient in sexual activity;” 9) terminating medical care “without adequate notice or without making arrangements for . . . continued care;” 10) failing to cooperate with a board investigation, unless the subject of the investigation; 11) “[v]iolating the probation agreement with [the] board;” 12) conduct that “might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence;” 13) disciplinary action by the board of another state or any licensing authority, including state
D. The Board’s Imposition of Discipline

After the AHC finds any cause charged by the board, it delivers to the board “the record and transcript of the [AHC] proceedings” together with its “findings of fact [and] conclusions of law,” as well as any disciplinary recommendation it may wish to make. 34 “Within thirty days after receipt of the [AHC’s] record of the proceedings,” the board must “set the matter for hearing upon the issue of . . . discipline,” unless the board and physician agree to waive the hearing, in which case the AHC’s recommendations become the board’s order. 35

The board may discipline physicians as follows: 1) refuse to renew a certificate of registration; 2) warn, censure, or place on probation; 3) suspend, restrict or revoke a license or issue a public or private reprimand; 4) require care, counseling or treatment; 5) attend continuing medical education (CME) courses; or 6) pass examinations. 36 The disciplines may be imposed singly or in combination. 37 Some disciplines are mandatory, such as automatic revocation for certain felony convictions. 38

E. Judicial Review of AHC and Board Decisions

Final decisions of the AHC are subject to judicial review. 39 AHC decisions are not final, however, until the final disciplinary order has been entered. 40 Otherwise, the court lacks subject matter jurisdiction. 41 For judicial review purposes, the actions of the AHC and the board’s disciplinary order are treated as one decision. 42

The standard of review for AHC decisions, governed by the Missouri Constitution, article V, § 18, is whether, considering the whole record, there is sufficient competent and substantial evidence to support the decision. 43 This standard is rarely unmet; only in cases where the decision “is contrary to the overwhelming weight of the evidence.” 44 Of course, courts review questions of law de novo. 45

“Proceedings for review [are] instituted by filing a petition in the circuit court of the county of proper venue within thirty days after the mailing or delivery of the notice of the . . . final decision.” 46 Venue, at plaintiff’s option, is “in the circuit court of Cole County or in the county of . . . plaintiff’s residence.” 47 Further judicial review is available from the appellate courts or the Supreme Court, in which case the AHC’s action, not the circuit court’s action, is reviewed. 48

F. Separate Consideration of Application Denials and Competency Hearings

1. Denial of Applications

The board has discretion to deny an application to issue or renew a license. 39 For example, the board has refused to issue licenses to physicians whose licenses were previously revoked for felony convictions. 40

Upon such a denial, applicants have recourse to the AHC. The applicant must file a written complaint. The AHC then conducts a hearing on the applicant’s qualifications and makes findings of fact and conclusions of law on the issues of whether the applicant is entitled to take the exam or, having passed the exam, licensure. 51 If the reason for the board’s denial of the application is low moral character or past unlawful acts, the AHC may determine whether the applicant has rehabilitated. Although the AHC can determine that there has been rehabilitation, it cannot direct the board to meet with the applicant and further consider his or her qualifications, as that is an improper delegation of its statutory duty to the board. 52

2. Competency Hearing – Board’s Exclusive Jurisdiction

Medical competency proceedings are exempted from AHC jurisdiction and are conducted by the board; 53 “the Board serves as investigator, prosecutor, judge, and jury.” 54

Initially, the board conducts a probable cause hearing to question the doctor’s competence. 55 Following the board finding probable cause, it “issue[s] an order setting forth the allegations leading to [the] finding . . ., the method of further determination of competency, [and] instructions to the competency panel,” including a time frame for determination. 56 After its determination, the competency panel issues one majority written report either that the physician “is able to practice with reasonable skill and safety[,]” or is unable to practice, “specifying the reasons or grounds for [its] opinion.” 57 After receipt of the report, the board notifies the physician and sets a meeting to formally accept the panel’s findings and determine a final order of discipline based upon the report and “any other evidence” that pertains to the issue of the final order. 58

Section 334.100.2(25) requires that the board have the physician submit to reexamination for the purpose of establishing his or her competency, or to submit to a mental or physical examination. When the board requires a doctor to undergo re-examination, it must send written notice. 59 If a physician fails to submit to examination, that “constitute[s] an admission of the allegations” and “the board may enter a final order without the presentation of evidence, unless the failure was due to circumstances beyond the physician’s control.” 60 If a physician is found competent, no further disciplinary action would be taken. 61

The procedure for determining competency must provide “a meaningful hearing with notice and an effective opportunity to defend” before a license is
suspended or revoked. Accordingly, in suspending or revoking a license for incompetency, the board cannot rely upon the evidence obtained at the probable cause hearing. At the contested hearing, the physician is entitled to cross-examine witnesses and to offer evidence contesting perceived deficiencies.

III. Legal Theories of Defense

A review of case law reveals theories by which successful challenges can be made to board and AHC findings.

A. Due Process and Equal Protection

A physician has a property interest in a medical license that is entitled to due process protection. The specifics of due process are dictated by balancing: (1) the private interests affected; (2) the risk of erroneous deprivation of the interest[s] through the procedures used and the probable value of additional procedural safeguards; and (3) the government’s interest, including . . . administrative burdens that additional” procedures would entail. At a minimum, procedural due process requires the opportunity to be heard at a meaningful time and in a meaningful manner. Thus, a physician is entitled to notice, the opportunity to cross-examine witnesses, “and a meaningful opportunity to present evidence contesting any perceived deficiencies.”

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B. Sufficiency of Proof

AHC findings of cause to discipline physicians have been successfully challenged on the basis that they are not “supported by substantial evidence.” For example, a finding of “gross negligence,” which the Supreme Court of Missouri has interpreted as meaning a “conscious indifference to a professional duty[,]” is not supported by the record where there is no testimony to that effect and there is a dispute as to whether there was, in fact, any negligence.

Similarly, a finding of “repeated negligence” is not supportable where the physician’s actions, analyzed under the “continuing care exception” to the statute of limitations, were all part of the same treatment decision, constituting a single negligent act. “Repeated negligence” has been found to include repeated departures from the standard of care involving more than one patient.

A finding that a physician is “incompetent” cannot be sustained where there was no testimony to that effect, no evidence of lack of qualifications, and there was only a single negligent act. Moreover, a finding of incompetence is not supported by the evidence where the record establishes that the physician has had multiple successes in extremely difficult and complex cases.

The term “unprofessional conduct” consists of specifications listed in § 334.100.2(4) (a)-(q). Any attempt to use grounds other than those specified would be subject to an attack for lack of notice. Unprofessional conduct is supported by a finding that a physician poked a nurse in anger in the operating room. It is also supported by a finding that a physician negligently “fail[ed] to recognize a failed bone fusion” while reporting to the patient that the fusion was progressing.

There must also be sufficient evidence of causation between the negligence and the injury. In other words, the evidence must meet the “but for” requirement. So, where a physician is charged with negligence for failing to refer a pregnant mother to a specialist for suspected fetal intrauterine growth retardation, there is insufficient evidence of causation when the child died of unrelated cord entanglement.

C. Expert Witness Evidence

Where a disciplinary action “deals with complex issues as to the appropriate medical care . . . , expert testimony is necessary to determine what standard of care” applies and whether the physician met that standard.

The admissibility of expert testimony is governed by § 490.065, RSMo. Expert testimony regarding “repeated negligence” under § 334.100.2(5) is the same as negligence in a civil case; namely, “that degree of skill and learning ordinarily used” by members of the profession in similar circumstances.
to discipline a physician for, among other things, repeated negligence in using chelation therapy to treat patients with vascular disease. In his support, Dr. McDonagh offered testimony of experts that his use of chelation therapy met the standard of care. All agreed that no controlled scientific studies found chelation therapy effective for this “off-label use.”88

After the AHC found for Dr. McDonagh, the board appealed, arguing 1) the experts’ opinions should have been excluded because no controlled studies existed to support them, and 2) the expert testimony failed to constitute substantial evidence because, although stating that Dr. McDonagh met the standard of care, the experts nowhere identified the standard of care.89

Regarding the admissibility of expert testimony, the Supreme Court of Missouri explained that § 490.065 does not require that expert opinions be supported by controlled scientific studies.90 Rather, admissibility of expert opinions depends on whether experts in that particular field can reasonably rely on other types of data in forming their opinions. As regards chelation therapy, although the lack of controlled studies presumably would be relevant, it might not be dispositive. It was for the AHC to consider the experts’ testimony, along with other evidence on the issue, and determine whether experts in the field could reasonably rely on the data those experts rely upon in reaching their conclusions.91 If so, the opinions were admissible.

Regarding the testimony as to the standard of care, the court explained that it was insufficient for the experts to merely testify that Dr. McDonagh’s treatment met the standard of care or that he complied with the views of a subgroup of practitioners.92 To be admissible, the experts would have to testify that, given these facts, Dr. McDonagh’s treatment demonstrated “the application of the degree of skill and learning ordinarily used by members of his profession.”93 If so, Dr. McDonagh’s use of chelation therapy would not be a basis for discipline, even if other doctors using the same facts would reach a different result.94 The Court then directed that the case be remanded to the AHC for further review in light of § 490.065 and the standard of care requirements.

As is seen, McDonagh demonstrates that AHC decisions may be subject to remand when they apply the wrong standard of care, or when they improperly consider or exclude expert testimony as to the standard of care and the physician’s compliance with it.95

D. Medical Judgment Rule

The “honest error of judgment” rule is recognized in medical malpractice law.96 It means that “as long as there is room for an honest difference of opinion among competent physicians, a physician who uses his or her own best judgment cannot be convicted of negligence” if later he or she was mistaken.97 This rule is not a “sure-fire loophole” to discipline, however, because the AHC is free to reject an expert’s testimony and find negligence.98

E. Statute of Limitations and Laches

Section 324.043 provides a three-year statute of limitations for disciplinary actions, except for proceedings based upon repeated negligence or sexual misconduct. The statute commences to run the date upon which the board received notice of the alleged violation.99

Although one physician accused of sexual misconduct argued that it was a denial of due process for the board to delay for five years before informing him of the charges, that argument was rejected because the physician failed to show prejudice.100

Similarly, for laches to apply the physician has the burden of proof showing prejudice that either 1) helpful evidence was lost, or 2) the doctor has changed his position in a way that would not have occurred but for the delay. Merely claiming that the physician could not locate favorable witnesses, without offering proof that he could not, or merely claiming that harmful publicity injured him, fails to establish laches.101

IV. Extraordinary Writs

Extraordinary writs have had limited success in physician disciplinary actions. A writ of prohibition has been used to challenge, ultimately unsuccessfully, the AHC’s failure to disqualify a commissioner.102 Similarly, a physician was unsuccessful in petitioning for a writ of prohibition after a trial court refused to enjoin the board from proceeding with a probable cause hearing in an incompetency case.103

V. Practical Considerations for Defending Disciplinary Actions104

In maneuvering through the disciplinary process, the preliminary determination must be whether the disciplinary charge is one that carries mandatory license revocation. For instance, the board must revoke the license of a physician who is convicted of a felony involving fraud or moral turpitude, or if a medical license is revoked in another state upon grounds for which revocation is authorized in Missouri.105 In such instances, the physician should address the underlying issue before the matter gets to the disciplinary stage. It would be imprudent to allow a criminal prosecution or license action in another state to go uncontested and rely upon the board’s leniency; the board has no discretion.

Aside from mandatory revocation situations, three general principles must be kept in mind in responding to disciplinary actions. First, where possible the board works with physicians to correct problems while protecting patients and promoting ethical standards within the medical profession. Second, the board favorably responds to straightforward cooperation. Third, the board rewards...
good faith, meaningful corrective action.

Applying the principles requires consideration of multiple factors, such as the nature of the likely discipline, the strength of the charge, the ease/difficulty with which corrective action can be taken, the potential adverse effect discipline may have on the physician’s career or practice, and the physician’s motivation to dispute or accept the charge.

VI. Conclusion

Physicians must vigorously defend underlying legal actions that could result in mandatory revocation. Once disciplinary actions are initiated, however, an informed judgment must be made as to how to respond. Although cooperation with the board is often advisable, sometimes it is not, and the attorney must be ready to employ the constitutional and statutory protections available to physicians in defending disciplinary actions.

Endnotes

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2 Under § 334.120, RSMo Supp. 2010, the board is responsible for “registering, licensing and supervising all physicians…”

3 Albanna v. State Bd. of Registration for the Healing Arts, 293 S.W.3d 423, 425 (Mo. banc 2009).

4 Section 334.100.2, RSMo Supp. 2010. Other bases for discipline include: 1) fraud in securing a certificate of registration; 2) use of “coercion or deception to obtain or retain a patient or discourage the use of a second opinion;” 3) “[m]isrepresenting that any disease” or ailment could “be cured by a method;” 4) “[p]erforming or prescribing medical services” declared by the board “to be of no medical value;” 5) failing to furnish “medical records to other treating physicians … upon proper request; or failing to comply” with other laws related to medical records; 6) failure to comply with a board subpoena; 7) “[f]ailure to timely pay license renewal fees;” 8) “[f]ailing to inform the board of … current residence and business address;” 9) advertising which is false or misleading, or which claims superior skill than other physicians; 10) assisting any other person in violating the statute; 11) impersonating any person holding a certificate of registration; 12) assisting any person to practice who is not registered and currently eligible; 13) “[f]ailure to display a valid certificate;” 14) knowingly making a false statement on birth, death or other certificate in connection with the profession; and 15) lacking the ability to practice as a physician with reasonable skill and safety due to incompetency, “illness, drunkenness, excessive use of drugs, narcotics or chemicals.”

5 Section 334.125, RSMo 2000, directs the board to “formulate rules and regulations to govern its actions.”

6 20 CSR §§ 2150-1.010, et seq.

7 20 CSR 2150-1.011(1)(A).

8 20 CSR 2150-1.011(2). Under § 383.105, RSMo Supp. 2010, medical malpractice insurers must report claims to the director of insurance. Under §383.125, RSMo 2000, the director reports the claims to the board.

9 20 CSR 2150-1.011(3). Under § 383.133, RSMo Supp. 2010, executives of hospital or...
ambulatory surgical center must report disciplinary actions to board. 
10 1 CSR 2150-1.101(4); Section 334.100.2, RSMo Supp. 2010. 
11 Sections 334.100.1 and 621.045.1, RSMo Supp. 2010. 
12 1 CSR 15-3.010, et seq. 
13 1 CSR 15-3.350. 
14 1 CSR 15-3.380. 
15 1 CSR 15-3.390. 
16 1 CSR 15-3.420 (discovery is in the same manner as provided for in the Supreme Court Rules). 
17 1 CSR 15-3.425. 
18 1 CSR 15-3.480. 
19 1 CSR 15-3.490. 
20 1 CSR 15-3.490(2); § 621.125, RSMo 2000. 
21 Section 621.150, RSMo Supp. 2010. 
22 Section 536.070(1), RSMo 2000. 
24 State Bd. for Registration for the Healing Arts v. McDonagh, 123 S.W.3d 146, 154 (Mo. banc 2003). 
25 Section 536.070 (2), RSMo 2000. 
27 Section 536.090, RSMo 2000. 
28 Section 536.068.2, RSMo 2000; 1 CSR 15-3.530. 
29 Section 621.110, RSMo Supp. 2010. 
30 Section 621.120, RSMo 2000. 
31 Section 621.110, RSMo Supp. 2010. 
32 Id. 
33 Section 536.087, RSMo 2000. Prevailing physician in AHC proceeding or related civil action “shall be awarded … reasonable fees and expenses” unless state’s position was substantially justified or that special circumstances make an award unjust.” 
34 Section 621.110, RSMo Supp. 2010. 
35 Id. 
36 Section 334.100.4, RSMo Supp. 2010. 
37 Id. 
38 See § 334.103, RSMo Supp. 2010. Cantrell v. State Bd. of Registration for the Healing Arts, 26 S.W.3d 824, 828 (Mo. App. W.D. 2000), holds that under § 334.103 the license of a physician who pleads guilty to the felony of fraudulently attempting to obtain a controlled substance is automatically revoked and the board lacks authority to stay the revocation. 
39 Section 621.145, RSMo 2000. 
40 Id. 
41 Lichtor v. Missouri Bd. of Registration for the Healing Arts, 884 S.W.2d 49, 52 (Mo. App. W.D. 1994) (court lacks subject matter jurisdiction for failure to exhaust administrative remedies where board has ordered physician to submit to retesting but date for retest has not yet arrived). 
42 Section 621.145, RSMo 2000. 
43 Albanna, 293 S.W.3d at 428. 
44 Id. 
45 Id. 
48 Albanna, 293 S.W.3d at 428. 
49 Section 334.100.1, RSMo Supp. 2010. 
51 Finch, 514 S.W.2d at 608. Under § 621.045, RSMo Supp. 2010, the AHC, not the board, conducts hearing and determines if physician who lost his license for a murder conviction has sufficiently rehabilitated to sit for licensing exam. 
52 De Vore, 517 S.W.2d at 484. 
54 Arman v. State Bd. of Registration for the Healing Arts, 918 S.W.2d 247, 250 (Mo. banc 1996); State ex rel. Walker v. Missouri State Bd. of Registration for the Healing Arts, 926 S.W.2d 148, 150 (Mo. App. E.D. 1996). 
55 20 CSR 2150-2.015; Cohyer, 257 S.W.3d at 143. 
56 20 CSR 2150-2.015(3). 
57 20 CSR 2150-2.015(5). 
58 20 CSR 2150-2.015(6). 
59 Section 334.100.2(5)(d), RSMo Supp. 2010; Cohyer, 257 S.W.3d at 143. 
60 Id. 
61 Cohyer, 257 S.W.3d at 143. 
62 Arman, 918 S.W.2d at 251. 
63 Cohyer, 257 S.W.3d at 146. 
64 Id. 
65 Cohyer, 257 S.W.3d at 144-45. 
66 Larocca v. State Bd. of Registration for the Healing Arts, 897 S.W.2d 37, 43 (Mo. App. E.D. 1995). 
67 Cohyer, 257 S.W.3d at 144. 
68 Cohyer, 257 S.W.3d at 146. 
69 Arman, 918 S.W.2d at 250-51. 
70 Cohyer, 257 S.W.3d at 145. 
71 Cohyer, 257 S.W.3d at 146; Arman, 918 S.W.2d at 251; Walker, 926 S.W.2d at 151. 
72 Arman, 918 S.W.2d at 251-52. 
73 Tendai v. Missouri State Bd. of Registration for the Healing Arts, 161 S.W.3d 358, 360 (Mo. banc 2005). 
74 Tendai, 161 S.W.3d at 367. 
75 Tendai, 161 S.W.3d at 369. 
76 Albanna, 293 S.W.3d at 431. 
77 Tendai, 161 S.W.3d at 369-70. 
78 Albanna, 293 S.W.3d at 435-36. 
79 Albanna, 293 S.W.3d at 431. 
80 Id. 
82 Albanna, 293 S.W.3d at 431. 
83 Tendai, 161 S.W.3d at 370. 
84 Id. 
85 McDonagh, 123 S.W.3d 146, 160, n. 16. 
86 McDonagh, 123 S.W.3d 146, 152-53. 
87 Id. at 159. 
88 Id. at 151. 
89 Id. at 157-58. 
90 Id. at 157. 
91 Id. 
92 Id. at 159. 
93 Id. 
94 Id. 
95 Id. at 146. 
96 Haase v. Garfinkel, 418 S.W.2d 108, 114 (Mo. 1967). 
97 Id. 
98 Albanna, 293 S.W.3d at 433. 
100 Larocca, 897 S.W.2d at 45. 
101 Id. 
102 Rosenberg, 233 S.W.3d 757. 
103 Walker, 926 S.W.2d 148. 
104 For a fuller discussion of the principles to keep in mind in preventing and responding to disciplinary action, see Edward Crites, The Regulation and Discipline of Physicians in Missouri, 31 St. Louis Med. Med. 18 (July/Aug. 2009). 
105 Cantrell, 26 S.W.3d 824.