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Court of Appeals
Division II
State of Washington

Case No. 48394-7-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

SHANTANU NERAVETLA, M.D.,

Petitioner,

v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

PETITION FOR REVIEW BY THE WASHINGTON SUPREME COURT

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I. **Introduction**

The Court of Appeals' Opinion effects an unprecedented expansion of the State's ability to sanction doctors pursuant to the RCW 18.130.170 based on an alleged "mental condition." Indeed, the Court of Appeals' Opinion essentially renders the term "mental condition" definition-less, subjecting doctors, who have never been diagnosed with any mental disorder or illness, to sanction and stigmatization based on their personality "traits" or "problems" or their alleged "behavior."

In this case, the State's own witnesses who testified at the administrative hearing found that Dr. Neravetla had no diagnosable disorder or illness. Moreover, Dr. Neravetla presented testimony from three esteemed experts at the hearing, each of whom testified that he was mentally fit to practice medicine. The Court of Appeals itself found that there was no evidence of incompetence, negligence or malpractice creating an unreasonable risk that a patient may be harmed. Nevertheless, it upheld a sanction based on a "mental condition."

This Opinion creates an amorphous and dangerous standard that subjects physicians to charges for an unlimited range of activity. It violates principles of statutory construction; improperly conflates the requirements of RCW 18.130.170, which regulates physicians with "mental conditions,"

and RCW 18.130.180, which regulates "unprofessional conduct;" and renders the term "mental condition" unconstitutionally vague.

Moreover, the Opinion will open the legal floodgates to challenges based on "mental condition" in the medical and legal professions.[1] The Court of Appeals' definition is inherently subjective, and subjects a wide range of workplace conduct to sanction. Section 170 was not intended to regulate workplace disputes, but rather significant, incapacitating mental and physical conditions that truly prevent a doctor from safely and skillfully practicing medicine. The Court of Appeals' Opinion dramatically undermines this purpose, and essentially guarantees numerous further filings based on subjective evaluations of behavior or conduct, rather than any identified mental condition.

II. Petitioner's Identity

Petitioner Shantanu Neravetla is the Appellant at the Court of Appeals, the Petitioner at the trial court, and the Respondent at the administrative hearing.

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[1] Although this case involved a medical license, the bodies of law related to legal and medical competency inform each other. Among other things, the Court of Appeals here relied on a case about a lawyer charged under a state bar disciplinary proceeding to support its definition of "mental condition" in the Opinion. Op. at 11 (citing *In Re Ryan,* 97 Wn.2d 284, 287 (1982) (addressing Washington State Bar Association rule related to "mental illness or other mental incapacity."). Thus, the Court of Appeals' Opinion in this matter is likely to inform state bar disciplinary proceedings as well.

III. <u>Citation to Appellate Decision to Be Reviewed</u>

Petitioner requests that the Washington Supreme Court review the Washington State Court of Appeals published opinion *Shantanu Neravetla, M.D. v. Department of Health, State of Washington*, Case No. 48394-7-II, Washington Court of Appeals, Division II (April 11, 2017), herein the "Opinion."

A copy of the Opinion is attached as Appendix A. A copy of RCW 18.130.170 and RCW 18.130.180 are attached as Appendix B. A copy of the Medical Quality Assurance Commission Policy on Disruptive Behavior, referenced by the Court of Appeals, is attached as Appendix C.

IV. <u>Issues Presented for Review</u>

This case presents an issue of substantial public interest that should be determined by the Supreme Court. Moreover, it raises a significant question under the U.S. Constitution, which also merits review by the Supreme Court.

The Revised Code of Washington Section 18.130.170(1) states that:

> [i]f the disciplining authority believes a license holder may be unable to practice with reasonable skill and safety to consumers *by reason of any mental or physical condition*, a statement of charges in the name of the disciplining

authority shall be served on the license holder and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety. If the disciplining authority determines that the license holder *is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection*, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public. (emphasis added)

The issues for review involve the scope of the term "mental condition" under the code, and include:

1. Did the Court of Appeals' Opinion improperly interpret the phrase "mental condition" under R.C.W. 18.130.170(1) to be defined to cover alleged evidence of "traits," "problems," and/or "behavior," despite no diagnosis whatsoever of a mental disorder, and testimony by three experts at hearing that the doctor at issue was fit to practice medicine?

2. Did the Court of Appeals' Opinion improperly conflate a finding under R.C.W. 18.130.170(1) of a "mental condition" based on alleged evidence of "traits," "problems," and/or "behavior," with RCW

18.130.180, which regulates unprofessional conduct in the medical profession?

3. Is the definition of "mental condition" under R.C.W. 18.130.170(1) as articulated by the Court of Appeals' Opinion unconstitutionally vague?

V. Statement of the Case

Dr. Neravetla was a 26-year-old physician when he began his transitional year residency in 2011 at Seattle's Virginia Mason Medical Center. Administrative Record ("AR") 1055; AR 1813; AR 2454. on June 24, 2011, Dr. Neravetla was granted a one-year license to practice medicine in Washington so that he could complete this residency. AR 3.

Based on a series of disputed events, Virginia Mason issued a referral for Dr. Neravetla to the Washington Physicians Health Program ("WPHP").[2] WPHP "informally assessed" Dr. Neravetla and referred him for further assessment, which was ultimately conducted by Pine Grove

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[2] Dr. Neravetla continues to vehemently disagree with the findings of the Panel and the Court of Appeals regarding any alleged conduct attributed to him, as such findings are based *wholly* on unsubstantiated hearsay testimony. For example, none of the "complaints" allegedly received by Dr. Dipboye were in evidence at the hearing. Nor were any performance reviews. However, for purposes of this Petition, Dr. Neravetla focuses on the legal parameters of the Court of Appeals' Opinion, rather than the alleged facts, since even the alleged facts fail to support a finding of "mental condition" under the code.

Behavioral Health. AR 1293-94; AR 2108-09; AR 21-15; AR 2120; AR 2133; AR 2158; AR 2162-63.

Pine Grove conducted assessments of Dr. Neravetla, but did not diagnose Dr. Neravetla with anything. Rather it suggested that he had certain traits, an "occupational problem," and mentioned "disruptive behavior." AR 2327; AR 2323; AR 2320.

The Medical Quality Assurance Commission ("MQAC") lodged a Statement of Charges against Dr. Neravetla on March 15, 2013, alleging that he was unable to practice medicine with reasonable skill and safety to consumers by reason of mental or physical condition, pursuant to RCW 18.130.170(1). No other statutory violation was alleged, and the Statement of Charges was never amended. AR 3-6.

At the hearing on April 21-23, 2014, the Department of Health presented testimony from staff of WPHP and Pine Grove. They all testified that no one had diagnosed Dr. Neravetla with any mental disorder. *See, eg.,* AR 2327, AR 2320; AR 2323 (Dr. Teresa Mulvihill of Pine Grove); AR 2269, ll 5-14; AR 2269, ll 15-25 (Ed Anderson, PhD, of Pine Grove).

Dr. Neravetla presented testimony from three preeminent experts, all of whom unequivocally stated that he had no disorder or condition that would render him unsafe to practice medicine, and that he was in fact fit to

practice medicine. *See* AR 2609-2614; AR 2633; AR 2655-66. These experts based their opinions on in-person meetings and testing with Dr. Neravetla and/or review of the records and assessments of the State's witnesses in the case. *See* AR 2651-55; AR 2633-34; AR 2608-2612.

Beyond that, the testimony at the hearing focused on his *conduct and behavior*. The only testimony regarding his conduct at work came from Dr. Keith Dipboye, the residency program supervisor, who only alleged he had secondhand reports of Dr. Neravetla's performance; Dr. Brian Owens, the director for graduate medical education, whose information about Dr. Neravetla primarily came from Dr. Dipboye; and Dan O'Connell, PhD, a career coach who had spent only a few hours with Dr. Neravetla.

Based on this hearing, on May 20, 2014 the MQAC issued Findings of Fact and Conclusions of Law that upheld the charges and issued sanctions against Dr. Neravetla. AR 1601-14. The Commission squarely ruled that "[t[here was no evidence presented, nor does the Commission find, that the Respondent suffers from a personality disorder." AR 1608, n.5. However, the Commission sanctioned Dr. Neravetla based on what it termed his "occupational problem," stating that this "occupational problem was disruptive to his internship; that it did interfere with his ability to communicate and work with others; and, that if

it persists, it would impede his ability to practice with reasonable skill and safety." AR 1610, ¶1.10(b) (emphasis added); *see also id.* (referencing MQAC policy on "disruptive behavior" as basis for decision); *compare* AR 1604, ¶1.3 (simultaneously finding that it had insufficient evidence to determine Dr. Neravetla's conduct during his residency).

The Commission ordered that should Dr. Neravetla, whose temporary license issued for the one year residency program had expired, ever seek licensure in the State of Washington again that he must obtain an evaluation from a WPHP referred evaluator and follow any subsequent recommendations. AR 1612, ¶3.1.

Dr. Neravetla sought reconsideration by the Commission, arguing, *inter alia,* that "disruptive behavior" does not constitute a mental condition. AR 1615-24; AR 1639, ¶6. This request was denied. AR 1777.

Dr. Neravetla appealed this decision to the Superior Court for the State of Washington, Thurston County, which affirmed the Commission's Order on October 14, 2015 via a mere two-and-a-half-page order. CP 371-73. Dr. Neravetla then filed a notice of appeal with the Court of Appeals, Division II, on November 25, 2015. The Court heard argument on December 9, 2016, and issued its Opinion on April 11, 2017.

Dr. Neravetla has not practiced medicine in Washington, or any other state, since leaving Washington nearly five years ago.

VI. Argument

A. Standard of Review

Issues pertaining to constitutional limitations and statutory authority are issues of law to be determined *de novo* by the Court. *Okeson v. City of Seattle,* 150 Wn.2d 540, 548-49 (2003); *In Re Schneider*, 173 Wn.2d 353, 358 (2011).

B. The Court of Appeals Improperly Expanded the Definition of Mental Condition Under Section 170; This Expansion Lacks Objective Criteria and Potentially Encompasses a Variety of Workplace Behaviors.

The Court of Appeals' determination that Section 170 can regulate behavior, problems or conduct flies in the face of multiple rules of statutory construction. Moreover, it creates an inherently subjective standard that leaves the ultimate determination to the personal and erroneous beliefs of the decisionmaker, thus potentially regulating a wide variety of workplace behavior.

The term "mental condition" is not defined by the Uniform Disciplinary Act ("UDA") or the Washington's statute adopting the UDA, Chapter 18.130 RCW. Nor has it been defined by case law, until now.[3]

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[3] However, in the criminal context, Washington Courts of Appeal have defined the term "mental condition" to mean "mental abnormality," "personality disorder," or "mental disability," that is established by a

However, the overall construction of the charging statute assumes that a diagnosis will be at issue. *See In re Estate of Mower*, 193 Wn. App. 706, 720 (2016) (avoid interpretations that would render superfluous a provision of the statute); and *State v. Roggenkamp*, 153 Wn.2d 614, 623-24 (2005) (a single word in a statute should not be read in isolation).

Section RCW 18.130.170 clearly anticipates that the mental condition would be *diagnosable* by a certified health professional because it authorizes the disciplinary authority to require a license holder to submit to a mental examination. *See, e.g.*, RCW 18.130.170(2)(a) ("the disciplining authority may require a license holder to submit to a mental or physical examination by one or more licensed or certified health professionals.") and RCW 18.130.170(2)(c) ("the license holder may submit physical or mental examination reports from licensed or certified health professionals.").

Therefore, RCW 18.130.170 requires a finding of some diagnosable mental condition before discipline can be pursued. If an objective medical determination of a mental condition were statutorily irrelevant, then there would be no need for the Legislature to authorize an independent medical examination.

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psychological diagnosis. *See, e.g., In re Det. Of Albrecht*, 129 Wn. App. 243, 250 (2005); *In re Det. Of Jacobson*, 120 Wn. App. 770, 781 (2004); *State v. Despenza*, 38 Wn. App. 645, 648 (1984).

Dr. Neravetla did exactly what the statute anticipated in this instance – he submitted "mental examination reports from licensed or certified health professionals." RCW 18.130.170(2)(c); *see also generally* 18.130.170(2)(a)-(d). What would reports from health professionals address, other than whether he was diagnosed with a disorder and whether he was mentally fit to practice medicine. If three experts testifying to mental fitness to practice medicine is insufficient to overcome a charge based on a "mental condition," there is no clear standard for what *would* suffice as a defense.

The Court of Appeals' citation to RCW 18.130.170(2)(f) to support its argument that "mental condition" extends beyond a mental illness or disorder is unpersuasive. Op. at 8. The Code's statement that *a determination by a court* that a license holder is "mentally incompetent or an individual with mental illness" is presumptive evidence of the license holder's inability to practice with reasonable skill and safety in no way suggests that the term "mental condition" can regulate conditions beyond those. In fact, it suggests the opposite – namely that the code is specifically concerned with mental incompetence or illness, and that a prior *judicial finding* of such constitutes presumptive evidence of a disqualifying "mental condition," without further inquiry.

Moreover, the Opinion's reliance on the MQAC's policy statement is no more persuasive. Op. at 8-9. The MQAC Policy Statement relied on by the Court of appeals *distinguishes between* disruptive behavior and a mental condition, stating that "disruptive behavior may be a sign of an illness or condition that may affect clinical performance." AR 1833. Further, there is nothing in the policy to indicate that it was issued to implement RCW 18.130.170, nor to put any doctor on notice that this policy was in any way intended to provide guidance on that statute, or inform the term "mental condition."

To the extent the Policy Statement attempts to describe a category of *conduct*, even that is incredibly vague and amorphous. The MQAC Policy Statement defines "disruptive behavior" as "[p]ersonal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)." MQAC Policy Statement, AR 1107 & Appx. C. It includes a wide range of activity including such relatively mild things as "difficulty working collaboratively with others," and "quietly exhibiting uncooperative attitudes during routine activities." *Id.* According to the Department, the consequences of "disruptive behavior" can also include a

wide range of things, including job dissatisfaction for staff – which is not at all uncommon in the workplace.

Thus, under the MQAC policy, even a quietly uncooperative attitude that results in job dissatisfaction can thus lead to charges as a mental condition under 170 – leading to quasi-criminal convictions and professional licensure sanctions. Moreover, many types of conduct entitled to protection under other types of workplace statutes can be subject to allegations of "disruptive behavior" or "occupational problem," thus leading to charges under 170. *Cf. Clark v. Columbia/HCA Info. Servs., Inc.* 117 Nev. 468, 473, 479 (Nev. 2001) (holding that alleged "disruptive conduct," in that matter mirrored conduct protected under whistleblowing laws). Particularly in the medical profession, public policy supports protections for medical professionals to speak out and challenge what they believe to be problematic conditions, without fear of reprisal in the form of a "disruptive behavior" label, and charges under 170.

C. The Court of Appeals Improperly Conflated Section 170, Which Regulates Mental Conditions, With Section 180, Which Regulates Conduct.

The Court of Appeals' Opinion conflates the requirements of 170 – which regulates mental conditions – with 180 – which regulates unprofessional conduct. Op. at 9. It did so, at least in part, on what it said

was Dr. Neravetla's failure to identify the specific conduct conflated. *Id.* However, what it failed to acknowledge or address is that by upholding a prosecution of Dr. Neravetla based on alleged conduct or behavior, the Court of Appeals (as the Department of Health before it) conflated the entire concept of *conduct* under 180, with a *mental condition* under 170. *Hallauer v. Spectrum Properties, Inc.,* 143 Wn. 2d 126, 146 (2001) (statutes which stand *in pari materia* are to be read together as constituting a unified whole, maintaining the integrity of the respective statutes). Indeed, the Court of Appeals' Opinion itself expressly applied its analysis to the alleged "actions" and "behavior" of Dr. Neravetla. Op. at 9.

By its express terms, RCW 18.130.180 regulates a specifically enumerated list of "*conduct, acts, or conditions constituting unprofessional conduct* for any license holder under the jurisdiction of this chapter." (emphasis added). In contrast, RCW 18.130.170 only discusses "conduct" insofar as it provides authority to compel physical and mental examinations, which requires the Department give written notice that includes, among other requirements, "a statement of the specific conduct, event, or circumstances justifying an examination." RCW 18.130.170 (2)(a)(i). In other words, *conduct* may put relevant parties on notice of a *condition*, but it is not itself sanctionable under 170. Indeed, other than providing grounds to compel a mental examination, conduct is not

mentioned anywhere in RCW 18.130.170, and is not included in the section related to hearings. In fact, RCW 18.130.170(1) states that "hearing shall be limited to the *sole* issue of the *capacity* of the license holder to practice with reasonable skill and safety." (emphasis added). The Department's position that it can regulate physician conduct under RCW 18.130.170 would render RCW 18.130.180 meaningless and superfluous and make meaningless the authority to compel a mental examination and the hearing provisions under 170.

Notably, the Court of Appeals recognized that none of Dr. Neravetla's alleged conduct would have merited sanctions under any of the categories of 180. Op. at 9. It found that there was not evidence of "incompetence, negligence or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed." Op. at 9, n.8 (citing RCW 18.130.180(4)). Further, while at the same time it found that there was not incompetence, negligence or malpractice that "creates an unreasonable risk that a patient may be harmed," it also found that Dr. Neravetla's hearing legitimately focused on his "ability to safely treat the public" – a distinction that is without a difference.

D. The Definition of Mental Condition Under the Court of Appeals' Opinion is Unconstitutionally Vague.

Here, the Court of Appeals held that the statute requires a "mental condition that affects a person's ability to work with patients safely," and that this does not require an actual diagnosable mental illness. Op. at 11. That definition is unconstitutionally vague, especially when the alleged "condition" is based on "problems" or "behavior."

The Due Process clause of the Fourteenth Amendment requires that citizens be afforded fair warning of proscribed conduct. *Rose v. Locke,* 423 U.S. 48, 49 (1975)*; see also Grayned v. Rockford,* 408 U.S. 104, 108 (1972); *Colten v. Kentucky,* 407 U.S. 104, 110 (1972). Under the due process clause, an ordinance is unconstitutionally vague if a challenger demonstrates, beyond a reasonable doubt, either (1) that the ordinance does not define the offense with sufficient definiteness that ordinary people can understand what conduct is proscribed, or (2) that the ordinance does not provide ascertainable standards of guilt to protect against arbitrary enforcement. *Kolender v. Lawson,* 461 U.S. 352, 357 (1983); *State v. Watson,* 160 Wn.2d 1, 6 (2007); *State v. Motherwell,* 114 Wn.2d 353, 369 (1990). An ordinance is unconstitutionally vague if either requirement is not satisfied. *E.g., Am. Dog Owners Ass'n v. City of Yakima,* 113 Wn.2d 213, 215 (1989).

Here, the fact that the concept of "disruptive physician behavior" is both ambiguous and not considered in and of itself a "mental condition" was again confirmed by the testimony of the witnesses at the hearing, including the State's witnesses. *See* AR 2329, ll 1-12; AR 2325, ll 19-23 (Dr. Mulvihill (State's witness) testified that "disruptive behavior" is *not* a "mental condition," and is just a "descriptive label."); AR 2203, ll 6-19 (Dr. Meredith (State's witness) testified that while others have "tried" to define it, it could be any variety of behaviors); AR 2258, ll 5-12 (Dr. Anderson (State's witness) testified that there are no standard measures for "disruptive behavior."). Even the Department's attorney conceded at hearing that "disruptive behavior" is not necessarily a "mental condition." AR 1861, ll 7-22.

The Court of Appeals' cited case of *In re Ryan*, actually makes clear that the nature of cases brought under statutes regulating professionals whose mental state puts their ability to practice in question is nowhere in the realm of this case, thus begging the question of where the line is drawn. Op. at 11 (citing *In re Ryan,* 97 Wn.2d 284 (1982)). In *Ryan*, a case addressing the ability to practice law because of mental illness or mental incapacity under an analogous statutory scheme, there was unequivocal evidence of mental incapacity or illness as those terms are commonly understood.

In *Ryan* a psychiatrist concluded that the attorney had "full-blown paranoid delusions" involving conspiracy theories in which he believed almost everyone he had met in recent years was involved. *Id.* at 287. Specifically, he believed that all of his cases were fabricated and not based on legitimate legal claims, and that everyone involved in the litigation, including the judge and jury, staged the disputes for his benefit. *Id.* at 285. The attorney went so far as to file two lawsuits pro se against his own clients, as well as other lawyers and businesses, alleging conspiracies (for example alleging his landlord was spying on him and exposing him to debilitating substances). *Id.* at 286. The case was based largely on Ryan's own court filings demonstrating his delusions.

The allegations in this matter – which were in no way substantiated at the administrative hearing – are a far cry from the type of findings demonstrated by *Ryan.* Indeed, allegations that a doctor was late or rude are wholly distinct from the type of behavior regulated by *Ryan*, nor are they what any doctor could expect to be regulated by 170. This is because 170 was not intended to regulate workplace disputes, but rather significant, incapacitating mental and physical conditions that truly prevent a doctor from safely and skillfully practicing medicine.

Further, *Haley v. v. Medical Disciplinary Bd.,* which was addressed by Petitioner in his briefs, but not addressed by the Court of

Appeals supports Dr. Neravetla's position regarding vagueness in this matter. *Haley,* 117 Wn.2d 720 (1991). In *Haley*, a surgeon was sanctioned under Section 180 for committing unprofessional conduct after having a sexual relationship with a minor who was a former patient.[4] *Id.* at 722-24, 731. This case addressed a challenge of constitutional vagueness regarding unprofessional conduct including "moral turpitude." *Id.* at 739-40. The court disagreed and set forth that where the language of the statute fails to provide an objective standard, the required specificity may be provided by reading the statute as a whole, and by the common knowledge and understanding of the members of the community. *Id.* at 741-744.

Here, the MQAC Policy Statement relied on by the Department throughout the administrative proceeding, and the Court of Appeals in its Opinion, *distinguishes between* disruptive behavior and a mental condition. AR 1833. To the extent the Policy Statement attempts to describe a category of *conduct*, even that is incredibly vague and amorphous. *See supra* Section IV.B.

As Supreme Court noted in *Nguyen*, these proceedings are already subjective, thus requiring exacting standards of proof. *Nguyen v. Dep't of Health,* 144 Wn.2d 516, 531 (2001) (citing *Cf. Tellevik v. Real Property,* 120 Wn.2d 68, 838 (1992) (ex parte probable cause hearing sufficient to

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[4] Again, a far cry from the nature of the allegations here.

meet minimal due process because the seizure determination was based on "an objective" standard arising from "'uncomplicated matters that lend themselves to documentary proof.'")). To compound that subjectivity by further adding a liberal and ill-defined category under which doctors can be charged, undermines the due process protections to which doctors are entitled.

VII. Conclusion

For the foregoing reasons, Dr. Neravetla respectfully requests that this Court accept review of this case.

Dated this 11th day of May, 2017.

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Appendix A

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Washington State
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Division Two

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

SHANTANU NERAVETLA, M.D., Appellant, v. DEPARTMENT OF HEALTH, STATE OF WASHIGNTON, Respondent.	No. 48394-7-II PUBLISHED OPINION

MELNICK, J. — Shantanu Neravetla, M.D. appeals the Department of Health, Medical Quality Assurance Commission's (MQAC) final order requiring him to undergo a psychological evaluation if he seeks licensure in Washington. MQAC found that Neravetla had a "mental condition" that affected his ability to practice with reasonable skill and safety.

We conclude that MQAC did not err in its interpretation of the term "mental condition" and that the statute at issue[1] is not unconstitutionally vague. Further, MQAC did not violate Neravetla's due process rights, sufficient evidence exists to support the decision, MQAC's decision was not arbitrary and capricious, and the presiding officer did not violate the appearance of fairness doctrine. We do not review the summary judgment motion denial or consider the evidentiary issues raised. We affirm.

[1] RCW 18.130.170.

FACTS

In June 2011, Neravetla began a one-year residency program at Virginia Mason Medical Center (VMMC) in Seattle. In the initial weeks of the program, the residency program director, Dr. Larry Keith Dipboye Jr., received complaints about Neravetla's performance. They related to his professionalism, accountability, attendance, communication, and patient care. Dipboye and Gillian Abshire, the manager of the Graduate Medical Education program, gave Neravetla a verbal warning. Nonetheless, Neravetla continued to have issues with attendance and communication. VMMC gave Neravetla a written warning and placed him on probation. A social worker also filed a patient safety alert with VMMC because of Neravetla's "belligerent" interactions with a nurse. Administrative Record (AR) at 1962.

Dipboye and VMMC then required Neravetla to attend coaching sessions and a class with Dan O'Connell, Ph.D., a psychologist and communication skills coach. O'Connell found Neravetla to be "bitterly angry, with little insight and little ability to reflect on his own behavior in relationships with others." Clerk's Papers (CP) at 25.

On February 9, 2012, VMMC referred Neravetla to the Washington Physicians Health Program (WPHP) for a mental status evaluation. The referral occurred because of Neravetla's interaction with the nurse in the patient safety alert incident and Neravetla's failure to take accountability for his actions or adequately process direct feedback on his behavior.

Two doctors from the clinical staff at WPHP evaluated Neravetla. Both doctors found Neravetla to be disconnected and non-responsive to queries. They also found him to be "confused, defensive, angry, and upset, raising his voice with the interviewers." CP at 25. He also brought WPHP's receptionist to tears. Based on their assessments, WPHP referred Neravetla to obtain a

comprehensive evaluation at Pine Grove Behavioral Health Center, one of three recommended evaluators.

Neravetla presented himself to Pine Grove without informing WPHP. Psychiatrist, Teresa Mulvihill, M.D., and psychologist, Ed Anderson, Ph.D., evaluated him. Anderson evaluated Neravetla as "defensive, lacking insight, blame-shifting, and denying and minimizing how his internship was at risk at VMMC." CP at 26. The Pine Grove evaluators made their evaluation based on their interactions with Neravetla, and information provided by both VMMC and Neravetla. Pine Grove diagnosed Neravetla with an "Occupational problem (disruptive behavior) (Axis I); and prominent obsessive-compulsive and narcissistic traits (R/O personality disorder NOS with obsessive-compulsive and narcissistic traits) (Axis II)."[2] CP at 26. The Pine Grove evaluators did not feel comfortable recommending that Neravetla return to his residency and recommended that before that occurred, he participate in an intensive six-week residential treatment. Pine Grove did not diagnose Neravetla with any mental illness.

WPHP reported Neravetla to MQAC. WPHP indicated its concern about Neravetla's ability to practice medicine because Neravetla had had no contact with WPHP and WPHP did not know where Neravetla was. WPHP did not know Neravetla had gone to Pine Grove for an evaluation. Subsequently, the residency program terminated Neravetla and VMMC held a grievance hearing. Neravetla's limited license expired in July 2012.

On March 18, 2013, MQAC issued charges against Neravetla. It alleged that sanctions should be imposed because Neravetla was "unable to practice with reasonable skill and safety pursuant to RCW 18.130.170(1)." AR at 5.

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[2] MQAC did not find that Neravetla suffered from a personality disorder.

Neravetla denied the allegations and asserted that no grounds existed to impose sanctions. He asserted defenses, including that he did not suffer from any mental disorder[3] and that MQAC lacked jurisdiction.

Neravetla filed a motion for summary judgment before MQAC, arguing that substantial evidence did not exist to prove he could not practice with reasonable skill and safety because of a mental condition. He included expert reports that concluded he had never been diagnosed with any mental illness and that he was fit for duty.

The presiding officer[4] denied Neravetla's motion for summary judgment because genuine issues of material fact existed regarding Neravetla's ability to practice with reasonable skill or safety because of a mental condition.

MQAC held a hearing on the charges. At the beginning of the hearing, the presiding officer asked a member of MQAC's panel, Dr. Thomas Green, a former VMMC employee, whether he could hear and assess the case in an impartial manner. Green stated that although he did know some of the people involved in the case, he had no doubt about his ability to give Neravetla a fair hearing. Green agreed to voice any concerns about his impartiality throughout the proceedings.

After hearing testimony, MQAC entered a final order and findings of fact and conclusions of law.[5] MQAC made specific credibility determinations in its findings of fact. MQAC determined that the clinic staff from WPHP were credible because their descriptions of their

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[3] Neravetla initially said he did not suffer from a narcissistic personality disorder, but later expanded it to any mental disorder.

[4] MQAC hearings are adjudicated by five MQAC members, with a presiding officer who is a "health law judge." AR at 1835.

[5] Neravetla does not assign error to any finding of fact. Findings of fact are verities on appeal. *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 407, 858 P.2d 494 (1993).

interactions with Neravetla were consistent. In addition, it found Pine Grove's staff and O'Connell to be credible.

MQAC accepted Anderson's conclusion that Neravetla suffered from the condition of Disruptive Physician Behavior, an occupational problem. Neravetla's demeanor as testified to by witnesses, was consistent with the diagnosis. MQAC found that this occupational problem interfered with Neravetla's ability to communicate and work with others, and if continued, would impede his ability to practice medicine safely. His occupational problem rose to the level that patient care would be adversely affected.

MQAC's conclusions of law stated in relevant part:

> 2.4 The Department proved by clear and convincing evidence that [Neravetla's] ability to practice with reasonable skill and safety was sufficient impaired by an occupational problem to trigger the application of RCW 18.130.170(1). . . .
> 2.5 In determining the appropriate sanctions, public safety must be considered before the rehabilitation of [Neravetla]. RCW 48.130.160. . . .
> 2.6 The Department requests that [Neravetla] be ordered to comply with the Pine Grove treatment recommendations. The Commission declines to do this.

CP at 32-33. The final order provided that if Neravetla sought licensure in Washington for a health care credential, he "shall undergo a psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation." CP at 33.

Neravetla filed a petition for judicial review to set aside MQAC's final order. The superior court affirmed the MQAC decision. Neravetla appeals.

ANALYSIS

I. Mental Condition

Neravetla argues that MQAC committed legal error by creating an "Amorphous and Arbitrary" standard for the term "Mental Condition." Br. of Appellant at 26. He also argues that

MQAC conflated the requirement that he have a mental condition that prevents him from practicing safely with unprofessional conduct.[6] We disagree.

A. LEGAL PRINCIPLES

We review this case under the Administrative Procedure Act (APA),[7] and directly review the agency record. *Ames v. Health Dep't Med. Quality Health Assurance Comm'n*, 166 Wn.2d 255, 260, 208 P.3d 549 (2009). We may reverse an administrative order (1) if it is based on an error of law, (2) if it is unsupported by substantial evidence, (3) if it is arbitrary or capricious, (4) if it violates the constitution, (5) if it is beyond statutory authority, or (6) when the agency employs improper procedure. *Ames*, 166 Wn.2d at 260; RCW 34.05.570(3) (a), (b), (c), (d), (e), (h), (i).

When reviewing an administrative agency decision, we review issues of law de novo. *Ames*, 166 Wn.2d at 260. We may "then substitute our judgment for that of the administrative body on legal issues." *Ames*, 166 Wn.2d at 260-61. However, we should "accord substantial weight to the agency's interpretation of the law it administers—especially when the issue falls within the agency's expertise." *Ames*, 166 Wn.2d at 261.

"[T]he challenger has the burden of showing the department misunderstood or violated the law, or made decisions without substantial evidence." *Univ. of Wash. Med. Ctr. v. Dep't of Health*,

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[6] We accepted an amicus curiae brief from the Legal Aid Society-Employment Law Center. Amicus raises many issues not raised by Neravetla. We may, but usually do not, reach arguments raised only by amicus. *State v. Duncan*, 185 Wn.2d 430, 440, 374 P.3d 83 (2016). We do not reach the issues raised solely in the amicus curiae brief.

MQAC filed a brief in response to amicus curiae's brief. Neravetla filed a motion to strike MQAC's appendix in its response brief to amicus curiae's brief. We grant Neravetla's motion to strike.

[7] Ch. 34.05 RCW.

164 Wn.2d 95, 103, 187 P.3d 243 (2008). "We do not reweigh the evidence." *Univ. of Wash. Med. Ctr.*, 164 Wn.2d at 103.

We review "a challenge to an agency's statutory interpretation and legal conclusions de novo under the error of law standard." *Greenen v. Wash. State Bd. of Accountancy*, 126 Wn. App. 824, 830, 110 P.3d 224 (2005). "If a statute's meaning is plain, then the court must give effect to the plain meaning as expressing what the legislature intended." *Campbell v. Dep't of Soc. & Health Servs.*, 150 Wn.2d 881, 894, 83 P.3d 999 (2004). We evaluate a statute's plain language to determine legislative intent. *Greenen*, 126 Wn. App. at 830. "Under the plain meaning rule, courts derive the meaning of a statute from the 'wording of the statute itself.'" *Strain v. W. Travel, Inc.*, 117 Wn. App. 251, 254, 70 P.3d 158 (2003) (quoting *Rozner v. City of Bellevue*, 116 Wn.2d 342, 347, 804 P.2d 24 (1991)).

"A statute is ambiguous when, either on its face or as applied to particular facts, it is fairly susceptible to different, reasonable interpretations." *Strain*, 117 Wn. App. at 254. If the plain language is ambiguous, we "may review the statute's legislative history, including legislative bill reports, to help determine a statute's intent." *Greenen*, 126 Wn. App. at 830. We examine the statute as a whole and its statutory interpretation must not create an absurd result. *State v. Larson*, 184 Wn.2d 843, 851, 365 P.3d 740 (2015)..

B. MQAC Correctly Interpreted the Law

1. The Term "Mental Condition"

Neravetla argues that MQAC incorrectly interpreted the term "mental condition" too broadly and that it must mean a diagnosable mental illness. We disagree.

The term "mental condition" is contained in RCW 18.130.170(1) which states:

> If the disciplining authority believes a license holder may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder and notice shall also be issued providing an opportunity for a hearing. *The hearing shall be limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety.* If the disciplining authority determines that the license holder is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

(Emphasis added).

Another section of this statute illustrates that the legislature recognized that a diagnosable mental illness is not synonymous with a mental condition. "A determination by a court of competent jurisdiction that a license holder is mentally incompetent or an individual with mental illness is presumptive evidence of the license holder's inability to practice with reasonable skill and safety." RCW 18.130.170(2)(f). The unambiguous plain language of the statute shows that a mental condition is not the equivalent of a diagnosable mental illness. The plain language provides that any mental condition that causes the license holder to be unable to practice safely would satisfy the statute. RCW 18.130.170(1). The goal of the statute is to protect consumers and insure that the license holder practices with reasonable skill and safety.

MQAC's policy statement defines disruptive behavior as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)" AR at 1107. MQAC's policy statement defines disruptive behavior as including conduct that interferes with one's ability to work with other members of the health care team. In addition, the statement provides examples of disruptive behavior including: difficulty working collaboratively with others, failing to respond to repeated calls, and responding poorly to corrective action. MQAC's policy statement states that hospitals should address a

practitioner exhibiting disruptive behavior "before the quality of care suffers, or complaints are lodged." AR at 1108. MQAC's policy statement provides support for its interpretation and conclusion that disruptive behavior can limit a practitioner's ability to practice with reasonable skill and safety.

Therefore, we conclude that MQAC did not err in its interpretation of the term "mental condition." Neravetla's occupational problem, disruptive physician behavior, would satisfy the requirements of the statute's provision despite not being a diagnosable mental illness in the Diagnostic and Statistical Manual.

2. MQAC Did Not Conflate Mental Condition with Unprofessional Conduct

Neravetla also argues that MQAC conflated the requirement that he have a mental condition that prevents him from practicing safely with unprofessional conduct. He claims this conflation constitutes a legal error because MQAC made conclusions that would only be appropriate under the latter statute that governs unprofessional conduct. We disagree.

RCW 18.130.180 lists approximately twenty-five types of "conduct, acts, or conditions [that] constitute unprofessional conduct for any license holder." However, none of the options listed relates to the alleged actions and behavior of Neravetla or the charges asserted against him. Neravetla does not identify which part of RCW 18.130.180 MQAC conflated with RCW 18.130.170.[8] MQAC focused on Neravetla's mental condition and his ability to safely treat the public and not whether he committed an act or conducted himself in an unprofessional manner.

[8] The only option that could possibly be related is: "Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed." RCW 18.130.180(4). Yet, Neravetla was not accused of incompetence, negligence, or malpractice, nor was there a specific event focused on by MQAC to establish one of the three.

Therefore, we conclude that MQAC did not err by its interpretation of the statute and that the argument that MQAC conflated the requirements of the statutes is without merit.

II. VAGUENESS

Neravetla argues that RCW 18.130.170 is unconstitutionally vague if the term "mental condition" includes undefined disruptive behavior because it opens the door for doctors to be charged for almost any type of conduct. He argues that if under RCW 18.130.170 disruptive behavior can be characterized as a mental condition, the statute is unconstitutionally vague. We disagree and conclude that the statute is not unconstitutionally vague.

The protections of due process apply to medical disciplinary proceedings. *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 739, 818 P.2d 1062 (1991). A vague statute offends due process. *In re Disciplinary Proceedings Against Curran*, 115 Wn.2d 747, 758, 801 P.2d 962 (1990). "Therefore, any statute under which sanctions may be imposed for unprofessional conduct must not be unconstitutionally vague." *Haley*, 117 Wn.2d at 739.

Statutes are presumed to be constitutional. *Haley*, 117 Wn.2d at 739. "The party challenging a statute's constitutionality on vagueness grounds has the burden of proving its vagueness beyond a reasonable doubt." *Haley*, 117 Wn.2d at 739. "A statute is void for vagueness if it is framed in terms so vague that persons 'of common intelligence must necessarily guess at its meaning and differ as to its application.'" *Haley*, 117 Wn.2d at 739 (quoting *Connally v. Gen. Constr. Co.*, 269 U.S. 385, 391, 46 S. Ct. 126, 70 L. Ed. 322 (1926)). The purpose of the vagueness doctrine is to ensure that citizens receive fair notice as to what conduct is proscribed, and to prevent the law from being arbitrarily enforced. *City of Seattle v. Eze*, 111 Wn.2d 22, 26, 759 P.2d 366 (1988).

"Some measure of vagueness is inherent in the use of language." *Haley*, 117 Wn.2d at 739. "[A] statute is not unconstitutionally vague merely because a person cannot predict with complete certainty the exact point at which his actions would be classified as prohibited conduct." *Eze*, 111 Wn.2d at 27. "[T]he common knowledge and understanding of members of the particular profession to which a statute applies may also provide the needed specificity to withstand a vagueness challenge." *Haley*, 117 Wn.2d at 743.

In *In re Ryan*, 97 Wn.2d 284, 287, 644 P.2d 675 (1982), Ryan challenged the discipline rules for the Washington State Bar Association, and argued that the terms "mental illness or other mental incapacity" were too vague to withstand constitutional challenge. In rejecting his argument, the court upheld the rules because "the mental condition must cause the attorney to be unable to conduct his/her law practice adequately. . . . Thus, the Bar must establish that an attorney is unable to conduct the practice of law adequately because of insanity, mental illness, senility, excessive use of alcohol or drugs, or other mental incapacity." *Ryan*, 97 Wn.2d at 288. The court further reasoned that "[g]iven the inherently uncertain nature of mental illness and the broad ranges of the practice of law, we fail to perceive how a more definite standard could be articulated, and Ryan has suggested none." *Ryan*, 97 Wn.2d at 288.

Here, the statute for physician discipline is similar because the mental condition must render the physician unable to practice medicine safely. Reading the statute as a whole, a person of common intelligence would likely conclude that the term does not require an actual diagnosable mental illness, only a mental condition that affects a person's ability to work with patients safely. Therefore, we conclude that the statute is not unconstitutionally vague.

III. Due Process Violations

Neravetla argues that the statement of charges violated his right to notice because it did not apprise him of the substance of the issues.[9] He argues that the substance of the proceedings changed to focus on his conduct and not whether he had a mental condition, so he was prejudiced in his ability to prepare evidence to counter MQAC's case. However, Neravetla fails to show how the alleged lack of notice prejudiced him. He only argues in his brief that at the prehearing conference he asked for more time to conduct more discovery and find additional witnesses and documents; MQAC denied the request.

In addition, he argues that the final order violates due process because it is impossible for him to comply with it. Because Neravetla received proper notice and because he could have complied with the order, we disagree.

A. Legal Principles

"Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment." *Mathews v. Eldridge*, 424 U.S. 319, 332, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976). "A medical license is a constitutionally protected property interest which must be afforded due process." *Nguyen v. Dep't of Health Med. Quality Assurance Comm'n*, 144 Wn.2d 516, 523, 29 P.3d 689 (2001). "[T]he applicability of the constitutional due process guaranty is a question of law subject to de novo review. *Durland v. San Juan County*, 182 Wn.2d 55, 70, 340 P.3d 191 (2014).

[9] It is not disputed that Neravetla held a protected property interest.

B. NOTICE OF THE ALLEGATIONS

Neravetla's argument that he did not receive notice of the charges is without merit. In a case involving disciplinary proceedings against an attorney, the charging document "must state the respondent's acts or omissions in sufficient detail to inform the respondent of the nature of the allegations of misconduct." *In re Disciplinary Proceeding Against Marshall*, 167 Wn.2d 51, 70, 217 P.3d 291 (2009) (internal quotations omitted). Due process requires that a respondent "be notified of clear and specific charges and . . . be afforded an opportunity to anticipate, prepare, and present a defense." *Marshall*, 167 Wn.2d at 70 (internal quotations omitted).

Here, Neravetla was apprised of the charges against him. The charging document stated that sanctions should be imposed because Neravetla was "unable to practice with reasonable skill and safety pursuant to RCW 18.130.170(1)." AR at 5. The statement of charges included a quote of RCW 18.130.170(1) that clearly identified Neravetla's inability to practice safely occurred because of a mental or physical condition. Neravetla claims he was only charged with a mental disorder, but he was actually charged with a mental condition. He also claims that the evidence focused on conduct, but that was evidence of a mental condition. In addition, the "alleged facts" section of the document explicitly described the facts MQAC relied on in asserting charges, including that he had an "occupational problem/disruptive behavior." AR at 4. Neravetla does not identify how this was insufficient other than the arguments we reject above. MQAC did not assert any other mental condition at the hearing, and therefore, Neravetla received adequate notice of the charges he faced. Accordingly, we conclude that Neravetla received sufficient notice of the charges against him.

C. Impossibility of Compliance with Final Order

Neravetla argues that the order violates his due process rights because it is impossible for him to comply. He asserts that the order's sanctions are "conditioned upon (1) Dr. Neravetla getting another residency position, and (2) getting that position in Washington." Br. of Appellant at 45. He claims he is unable to satisfy the order unless those preconditions are met. We disagree with Neravetla's interpretation of the order; he can comply with it.

The order provides: "In the event that [Neravetla] seeks licensure in the state of Washington for a health care credential, [Neravetla] shall undergo a psychological evaluation by a WPHP approved evaluator and follow whatever recommendations are contained in that evaluation." CP at 33. The order does not require Neravetla to seek another residency in Washington. It merely states what he must do if he seeks licensure in Washington for a health care credential. Because Neravetla can comply with the order, it does not violate his due process rights and his argument fails.

IV. Insufficient Evidence

Neravetla argues that substantial evidence did not support the finding that he could not practice medicine with reasonable skill and safety.[10] We disagree.

Neravetla did not assign error to the agency's findings of fact in the final order, therefore, they are verities on appeal. *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 407, 858 P.2d 494 (1993). We must determine whether the findings in turn support the conclusions of law and judgment. *Nguyen*, 144 Wn.2d at 530. Because the findings of fact are verities, we address only whether the findings of fact support MQAC's conclusions of law.

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[10] Neravetla is actually challenging MQAC's conclusion of law and claiming that it does not flow from the findings of fact.

MQAC's conclusion of law 2.4 provides: "The Department proved by clear and convincing evidence that [Neravetla's] ability to practice with reasonable skill and safety was sufficient[ly] impaired by an occupational problem to trigger the application of RCW 18.130.170(1)." CP at 32.

Numerous findings support MQAC's conclusion of law. O'Connell, whose testimony MQAC adopted, described Neravetla as "bitterly angry, with little insight and little ability to reflect on his own behavior in relationships with others." CP at 25. MQAC also adopted the testimony of the WPHP evaluators in its findings. They experienced Neravetla to be "confused, defensive, angry, and upset, raising his voice with the interviewers." CP at 25. In addition, at Pine Grove, Anderson experienced Neravetla as "defensive, lacking insight, blame-shifting, and denying and minimizing how his internship was at risk at VMMC." CP at 26.

MQAC accepted the final opinion from Pine Grove that Neravetla had an occupational problem, disruptive physician behavior. MQAC found that this occupational problem interfered with Neravetla's ability to communicate and work with others, and if continued, it would impede his ability to practice medicine safely. His occupational problem rose to the level that patient care was affected. Accordingly, its conclusion of law that Neravetla's disruptive physician behavior, a mental condition, prevented him from practicing with reasonable skill and safety flows from the findings of fact.

Therefore, we conclude sufficient evidence exists to support MQAC's decision and order that Neravetla's ability to practice with reasonable skill and safety was sufficiently impaired by an occupational problem, disruptive physician behavior, to trigger the application of RCW 18.130.170(1).

V. ARBITRARY AND CAPRICIOUS DECISION

Neravetla argues that MQAC's decision was arbitrary and capricious because it relied on unreliable hearsay and conflicting information to support its ruling. In addition, he argues the decision was arbitrary and capricious because the panel disregarded the testimony of his witnesses. He further argues that the panel arbitrarily discounted positive collateral information about him. We disagree with Neravetla and conclude that MQAC's order was not arbitrary and capricious.

Under RCW 34.05.570(3)(i), we shall grant relief from an agency order if the order is arbitrary and capricious. An agency order is arbitrary or capricious "if it is willful, unreasoning, and issued without regard to or consideration of the surrounding facts and circumstances." *Manke Lumber Co. v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd.*, 113 Wn. App. 615, 623, 53 P.3d 1011 (2002). Action taken by a disciplinary board after giving a licensee ample opportunity to be heard, "'exercised honestly and upon due consideration,'" is not arbitrary and capricious even if an erroneous conclusion has been reached. *Keene v. Bd. of Accountancy*, 77 Wn. App. 849, 860, 894 P.2d 582 (1995) (quoting *Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 483, 663 P.2d 457 (1983)). The scope of review under this standard is "very narrow" and the party seeking to demonstrate that the action is arbitrary and capricious "must carry a heavy burden." *Pierce County Sheriff v. Civil Serv. Comm'n of Pierce County*, 98 Wn.2d 690, 695, 658 P.2d 648 (1983).

Here, Neravetla argues that the order was arbitrary and capricious because MQAC found there was insufficient evidence to make a determination as to what actually happened in his residency, but then also found on the same information that he engaged in disruptive behavior. He also argues that the panel identified hearsay testimony about events that occurred during Neravetla's residency to be unreliable, but then made conclusions premised on the same information.

Although Neravetla does not identify the statements he challenges, our independent review of the record is that MQAC made the following finding of fact. "There was conflicting testimony, much of it hearsay, concerning [Neravetla's] conduct, performance, attendance, and professionalism while in the residency program at VMMC. With the exception of Dr. O'Connell's testimony, which the Commission finds credible, and [Neravetla's] own admission of missing certain classes, the Commission makes no finding regarding [Neravetla's] conduct during his residency except to note that [Neravetla] had difficulty in relationships with some of his supervisors." AR at 1604.

MQAC accepted Pine Grove's diagnosis that Neravetla had an occupational problem, disruptive physician behavior. Neravetla misinterprets MQAC's finding and what it was based on. Therefore, Neravetla's argument is without merit.

Next, Neravetla argues that the decision was arbitrary and capricious because MQAC disregarded the testimony of all of his expert witnesses. This argument is without merit, because we do not review credibility determinations. *State v. Camarillo*, 115 Wn.2d 60, 71, 794 P.2d 850 (1990).. The panel below is in the best position to determine whether a witness is credible. *See Camarillo*, 115 Wn.2d at 71. In addition, MQAC did find Neravetla and his witnesses to be credible, it just gave less weight to their testimony for reasons articulated in the final order. Regardless, even if the panel discounted favorable evidence, it may do so.

Neravetla fails to show the MQAC order is invalid for any reason specified by the controlling statute. Therefore, we conclude that the decision was not arbitrary and capricious.

VI. APPEARANCE OF FAIRNESS DOCTRINE

Neravetla argues that the presiding officer violated the appearance of fairness doctrine by allowing a former employee of the involved hospital, Green, to remain on the panel.[11] He argues that the presiding officer should have conducted an independent inquiry into whether Green could remain impartial. We conclude that the presiding officer did not violate the appearance of fairness doctrine.

A medical professional's license represents a property interest and cannot be revoked without due process. *Johnston*, 99 Wn.2d at 474. A basic requirement of due process is a "'fair trial in a fair tribunal.'" *Withrow v. Larkin*, 421 U.S. 35, 46, 95 S. Ct. 1456, 43 L. Ed. 2d 712 (1975) (quoting *In re Matter of Murchison*, 349 U.S. 133, 136, 75 S. Ct. 623, 99 L. Ed. 942 (1955)). A biased decision maker violates this basic requirement, which applies to administrative agencies as well as courts. *Withrow*, 421 U.S. at 47. The appearance of fairness doctrine "provides additional protection because it requires that the agency not only act fairly but must also do so with the appearance of fairness." *Clausing v. State*, 90 Wn. App. 863, 874, 955 P.2d 394 (1998). Pursuant to this doctrine, a judge must recuse herself "if [she] is biased against a party or [her] impartiality may reasonably be questioned." *State v. Dominguez*, 81 Wn. App. 325, 328, 914 P.2d 141 (1996). However, a party claiming bias must produce "[e]vidence of a judge's actual or potential bias . . . before the appearance of fairness doctrine will be applied." *Dominguez*, 81 Wn. App. at 329.

[11] Although Neravetla specifically argues that the presiding officer, and not Green, violated the appearance of fairness doctrine, his arguments seem to center on Green's involvement. Even though Neravetla does not argue it, nothing in the record demonstrates that Green could not be fair and unbiased in hearing the evidence and deciding the case.

"Under the appearance of fairness doctrine, proceedings before a quasi-judicial tribunal are valid only if a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." *Johnston*, 99 Wn.2d at 478. But the presumption is that administrative decision makers perform their duties properly and the party claiming a violation must present specific evidence to the contrary, not speculation. *Faghih*, 148 Wn. App. at 843.

Neravetla fails to demonstrate how the presiding officer violated the appearance of fairness doctrine. Although VMMC previously employed Green and he acknowledged he knew the names of some of the witnesses, Neravetla did not demonstrate that Green had an actual or potential bias. Accordingly, there is no evidence in the record to show that either the presiding officer or the panel was partial. Therefore, Neravetla's argument fails.

VII. Errors by Presiding Officer

Neravetla argues that the presiding officer committed multiple prejudicial errors including denying his motion for summary judgment, refusing to admit his experts' reports, and excluding probative evidence. We do not consider any of these arguments.

A. Motion for Summary Judgment

Neravetla argues that the presiding officer erred by denying his motion for summary judgment. Where a denial of summary judgment is based on existence of disputed material facts, we will not review it when raised after a trial on the merits. *Weiss v. Lonnquist*, 173 Wn. App. 344, 354, 293 P.3d 1264 (2013).

Here, the presiding officer denied Neravetla's motion for summary judgment because issues of material fact remained. MQAC held a trial on the merits of the issue thereafter. Therefore, we do not review MQAC's denial of the summary judgment motion.

B. Exclusion of Experts' Reports

Neravetla argues that the presiding officer refused to allow him to submit three expert witnesses' reports as exhibits, and he would only allow the reports to be admitted if he did not conduct direct examination of his witnesses.

Despite Neravetla's assertions, he did not actually offer the reports into evidence. The presiding officer broached the topic on his own before Neravetla began presenting his case. But the presiding officer made no ruling on the reports' admission, and therefore, there is nothing for us to review. In addition, the presiding officer did not limit Neravetla's ability to conduct direct examination of his witnesses.

C. Other Evidentiary Issues

Neravetla argues that the presiding officer excluded probative evidence and that he prohibited him "from introducing into evidence various documents." Br. of Appellant at 49. Neravetla also argues that the presiding officer "allowed Department attorneys to utilize documents handed to them by VMMC's counsel" that were not disclosed to him beforehand.

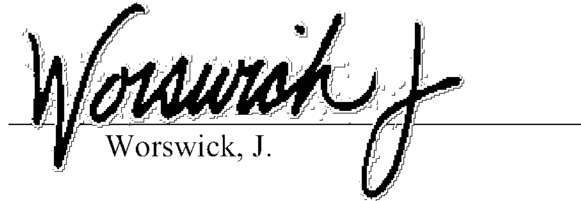
Neravetla's brief cites to the record only in regard to the exclusion of testimony from one witness, Dr. John Roberts. Neravetla wanted to call Roberts as a rebuttal witness. The presiding officer asked him to make a proffer. Neravetla said that Roberts would testify consistently with other prior testimony that Neravetla was accepting of feedback. He claimed the testimony was to rebut the allegations by Anderson that Roberts did not know of Dipboye's concerns. The presiding officer did not allow him to testify because the testimony would not have been inconsistent with what Anderson testified to, and did not qualify as rebuttal testimony. Neravetla does not identify other documents he claims were excluded.

Neravetla does not cite to any law to support his arguments nor does he provide any reasoning as to why the presiding officer's actions were error. Accordingly, we do not consider the evidentiary issues. *Bercier v. Kiga*, 127 Wn. App. 809, 824, 103 P.3d 232 (2004); RAP 10.3(a)(6).

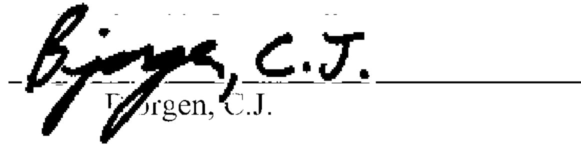
We affirm.

Melnick, J.

We concur:



Worswick, J.



Bjorgen, C.J.

Appendix B

RCW 18.130.170

Capacity of license holder to practice—Hearing—Mental or physical examination—Implied consent.

(1) If the disciplining authority believes a license holder may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder to practice with reasonable skill and safety. If the disciplining authority determines that the license holder is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW **18.130.160** as is deemed necessary to protect the public.

(2)(a) In investigating or adjudicating a complaint or report that a license holder may be unable to practice with reasonable skill or safety by reason of any mental or physical condition, the disciplining authority may require a license holder to submit to a mental or physical examination by one or more licensed or certified health professionals designated by the disciplining authority. The license holder shall be provided written notice of the disciplining authority's intent to order a mental or physical examination, which notice shall include: (i) A statement of the specific conduct, event, or circumstances justifying an examination; (ii) a summary of the evidence supporting the disciplining authority's concern that the license holder may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, and the grounds for believing such evidence to be credible and reliable; (iii) a statement of the nature, purpose, scope, and content of the intended examination; (iv) a statement that the license holder has the right to respond in writing within twenty days to challenge the disciplining authority's grounds for ordering an examination or to challenge the manner or form of the examination; and (v) a statement that if the license holder timely responds to the notice of intent, then the license holder will not be required to submit to the examination while the response is under consideration.

(b) Upon submission of a timely response to the notice of intent to order a mental or physical examination, the license holder shall have an opportunity to respond to or refute such an order by submission of evidence or written argument or both. The evidence and written argument supporting and opposing the mental or physical examination shall be reviewed by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or a neutral decision maker approved by the disciplining authority. The reviewing panel of the disciplining authority or the approved neutral decision maker may, in its discretion, ask for oral argument from the parties. The reviewing panel of the disciplining authority or the approved neutral decision maker shall prepare a written decision as to whether: There is reasonable cause to believe that the license holder may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, or the manner or form of the mental or physical examination is appropriate, or both.

(c) Upon receipt by the disciplining authority of the written decision, or upon the failure of the license holder to timely respond to the notice of intent, the disciplining authority may issue an order requiring the license holder to undergo a mental or physical examination. All such mental or physical examinations shall be narrowly tailored to address only the alleged mental or physical condition and the ability of the license holder to practice with reasonable skill and safety. An order of the disciplining authority requiring the license holder to undergo a mental or

physical examination is not a final order for purposes of appeal. The cost of the examinations ordered by the disciplining authority shall be paid out of the health professions account. In addition to any examinations ordered by the disciplining authority, the license holder may submit physical or mental examination reports from licensed or certified health professionals of the license holder's choosing and expense.

(d) If the disciplining authority finds that a license holder has failed to submit to a properly ordered mental or physical examination, then the disciplining authority may order appropriate action or discipline under RCW **18.130.180**(9), unless the failure was due to circumstances beyond the person's control. However, no such action or discipline may be imposed unless the license holder has had the notice and opportunity to challenge the disciplining authority's grounds for ordering the examination, to challenge the manner and form, to assert any other defenses, and to have such challenges or defenses considered by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or a neutral decision maker approved by the disciplining authority, as previously set forth in this section. Further, the action or discipline ordered by the disciplining authority shall not be more severe than a suspension of the license, certification, registration, or application until such time as the license holder complies with the properly ordered mental or physical examination.

(e) Nothing in this section shall restrict the power of a disciplining authority to act in an emergency under RCW **34.05.422**(4), **34.05.479**, and **18.130.050**(8).

(f) A determination by a court of competent jurisdiction that a license holder is mentally incompetent or an individual with mental illness is presumptive evidence of the license holder's inability to practice with reasonable skill and safety. An individual affected under this section shall at reasonable intervals be afforded an opportunity, at his or her expense, to demonstrate that the individual can resume competent practice with reasonable skill and safety to the consumer.

(3) For the purpose of subsection (2) of this section, a license holder governed by this chapter, by making application, practicing, or filing a license renewal, is deemed to have given consent to submit to a mental, physical, or psychological examination when directed in writing by the disciplining authority and further to have waived all objections to the admissibility or use of the examining health professional's testimony or examination reports by the disciplining authority on the ground that the testimony or reports constitute privileged communications.

[**2008 c 134 § 11; 1995 c 336 § 8; 1987 c 150 § 6; 1986 c 259 § 9; 1984 c 279 § 17**.]

NOTES:

Finding—Intent—Severability—2008 c 134: See notes following RCW **18.130.020**.

Severability—1987 c 150: See RCW **18.122.901**.

Severability—1986 c 259: See note following RCW **18.130.010**.

RCW 18.130.180

Unprofessional conduct.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter **9.96A** RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by *RCW **18.130.345**, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter **9.96A** RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter **19.68** RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

[**2010 c 9 § 5; 2008 c 134 § 25; 1995 c 336 § 9; 1993 c 367 § 22.** Prior: **1991 c 332 § 34; 1991 c 215 § 3; 1989 c 270 § 33; 1986 c 259 § 10; 1984 c 279 § 18.**]

NOTES:

***Reviser's note:** RCW **18.130.345** was repealed by **2015 c 205 § 5.**

Intent—2010 c 9: See note following RCW **69.50.315**.

Finding—Intent—Severability—2008 c 134: See notes following RCW **18.130.020**.

Application to scope of practice—Captions not law—1991 c 332: See notes following RCW **18.130.010**.

Severability—1986 c 259: See note following RCW **18.130.010**.

Appendix C

Department of Health
Medical Quality Assurance Commission

Policy Statement

Title:	Practitioners Exhibiting Disruptive Behavior	*Number: MD2012-01*
References:		
Contact:	Julie Kitten, Program Operations Manager	
Phone:	360-236-2757	
Email:	julie.kitten@doh.wa.gov	
Effective Date:	February 24, 2012	
Supersedes:		
Approved By:	Signature on file Mimi Pattison, MD, FAAHPM, Chair	

Conclusion: Disruptive behavior by physicians and physician assistants is a threat to patient safety and clinical outcomes. The Medical Quality Assurance Commission will take appropriate action regarding practitioners who engage in disruptive behavior.

Background. Disruptive behavior by physicians has long been noted but until recently there has been little consensus that such behavior has an adverse effect on patient safety or clinical outcomes, and therefore the behavior has often been tolerated. This was particularly true when the physician appeared to be clinically competent. However, in the past ten years it has been generally recognized that disruptive behavior poses a potential threat to patient safety.[1] The Joint Commission has said that "intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments."[2]

Definition and examples. The American Medical Association has defined disruptive behavior as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.)"[3] The Joint Commission describes intimidating and disruptive behaviors as including overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.

Dr. Kent Neff, a psychiatrist and recognized expert in this field, describes disruptive behavior as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[4] Examples of disruptive behavior may include:

*Profane or disrespectful language
*Demeaning behavior
*Sexual comments or innuendo
*Inappropriate touching, sexual or otherwise
*Racial or ethnically oriented jokes
*Outbursts of anger
*Throwing instruments or charts
*Criticizing hospital staff in front of patients or other staff
*Negative comments about another physician's care
*Boundary violations with staff or patients
*Comments that undermine a patient's trust in a physician or hospital
*Inappropriate chart notes, e.g., criticizing a patient's hospital treatment
*Unethical or dishonest behavior
*Difficulty in working collaboratively with others
*Failure to respond to repeated calls
*Inappropriate arguments with patients, families
*Poor response to corrective action

Most health care professionals enter their discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of physicians carry out their duties professionally and maintain high levels of responsibility. However, several studies and surveys identify the prevalence of disruptive behavior among physicians as somewhere between 1 and 5%.[5] "The importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasingly evident." [6] Such behavior disrupts the effectiveness of team communication and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events. [7] The consequences of disruptive behavior include job dissatisfaction for staff, including other physicians and nurses, voluntary turnover, increased stress, patient complaints, malpractice suits, medical errors, and compromised patient safety. Moreover, disruptive behavior may be a sign of an illness or condition that may affect clinical performance. Studies have shown that physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of Axis I and II psychiatric disorders, major depression, substance abuse, dementia, and non-Axis I and II disorders such as anxiety disorder, attention-deficit hyperactivity disorder, obsessive-compulsive disorder, sleep disorder, and other illnesses, most of which were treatable.[8]

Policy. When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment,

education, a systems approach and a strong aftercare program.[9] The Joint Commission has developed a leadership standard that addresses disruptive and inappropriate behaviors by requiring a code of conduct that defines unacceptable, and disruptive and inappropriate behaviors and a process for managing such behaviors.[10]

When the Medical Quality Assurance Commission receives a complaint concerning a practitioner exhibiting inappropriate and disruptive behavior, the Commission will consider such behavior as a threat to patient safety that may lead to violations of standards of care or other medical error. The Commission may investigate such complaints and take appropriate action, including possible suspension, to promote and enhance patient safety.

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1 Williams, B. W., and Williams M.V., The Disruptive Physician: A Conceptual Organization, Journal of Medical Licensure and Discipline, Vol. 94, No. 3, 12-20, 2008.
2 The Joint Commission, Sentinel Event Alert, Issue 40, July 9, 2008.
3 American Medical Association, E-9.045 Physicians with disruptive behavior (Electronic Version). AMA Policy Finder 2000. Cited in Williams and Williams, J. Med. Lic. & Disc. Vol. 94, No. 3, p.12, 2008
4 Neff, K., Understanding and Managing Physicians with Disruptive Behaviors, pp. 45 – 72,
5 Op. cit., Williams and Williams, p. 13
6 Ibid.
7 Ibid.
8 Williams and Williams, p. 14.
9 Williams and Williams, p. 17.
10 Op. cit.,The Joint Commission.

CERTIFICATE OF SERVICE

I, Shawna L. Parks, certify and state as follows:

1. I am a citizen of the United States and a resident of the state of California; I am over the age of 18 years and not a party of the within entitled cause. I am the principal in the Law Office of Shawna L. Parks, which address is 4470 W. Sunset Blvd., Suite 107-347, Los Angeles, CA 90027.

2. I caused to be served upon counsel of record at the address and in the manner described below, on May 11, 2017, the following document: Appellant's Opening Brief.

Tracy L. Bahm	[ ] U.S. Mail
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Olympia, WA 98504-0100	
TracyB@ATG.wa.gov	
Counsel for Respondent	

I hereby declare under the penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

DATED at Los Angeles, California on this 11th day of May, 2017.

Shawna L. Parks

LAW OFFICE OF SHAWNA L. PARKS

May 11, 2017 - 3:35 PM

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