

Case No. 48394-7-II

**COURT OF APPEALS, DIVISION II  
OF THE STATE OF WASHINGTON**

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SHANTANU NERAVETLA, M.D.,

Appellant,

v.

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

Respondent.

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**APPELLANT'S REPLY BRIEF**

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## **I. Introduction**

The Department takes the extraordinary position that RCW 18.130.170 regulates any “mode or state of being” and/or “conduct” of doctors, without any objective diagnosis whatsoever. Respondent’s Brief (RB) at 21 & 23. The Department’s dangerous, unprecedented attempt at unfettered expansion of this quasi-criminal statute flies in the face of every principle of statutory construction and Constitutional protections for doctors, such as Dr. Neravetla, who have significant rights affected by these cases and who suffer career-ending and life-altering consequences as a result.

The Department concedes that no diagnosis or disorder was at issue in this case, despite a statutory scheme that clearly anticipates mental examinations of doctors against whom charges are filed. Instead, the Department relies on the erroneous argument that broad terms, such as “occupational problem” or “disruptive behavior,” constitute mental conditions. It does so despite the fact that this argument is belied both by the testimony of the witnesses in this case and the Department’s own policy guidance, all of which clearly indicate that these terms are not, in and of themselves, mental conditions.

To support its fatally flawed arguments, the Department further relies on unsubstantiated, second-hand allegations of conduct from one of

the primary defendants in Dr. Neravetla's federal lawsuit, Dr. Dipboye. Indeed, not a single person who worked directly with Dr. Neravetla testified at the hearing. In light of the stark unreliability of the evidence, the Panel specifically stated it was making no findings as to Dr. Neravetla's conduct during his residency.

Notably, however, all of the State's witnesses who argued that Dr. Neravetla had an "occupational problem" and/or "disruptive behavior" based these conclusions on the same unreliable second-hand information that the Panel itself rejected. Despite this, the Panel capriciously relied on these witnesses' findings, regardless of the fact that it declined to rely on the same underlying and unreliable information at the hearing itself.

In contrast, the Panel rejected without legitimate justification all three of Dr. Neravetla's experts who testified at hearing and who found that he had neither a mental disorder nor condition, *and was fit to work as a doctor*. Indeed, the Panel's actions echo the approach throughout these proceedings – ignoring or excluding any positive reports or assessments, while only focusing on the unsupported, negative ones.

In sum, the Panel's order and the Department's arguments are fatally flawed, as both a matter of law and fact, and set a dangerous precedent that jeopardizes the fundamental rights of doctors in this quasi-criminal setting – rights that have been clearly identified by the

Washington Supreme Court in *Nguyen v. Dept. of Health*, 144 Wn.2d 516, 531 (2001). As such, the Panel’s order must be overturned and all sanctions against Dr. Neravetla rescinded.

## **II. Argument**

### **A. The State’s Position That the Charging Statute Requires No Principled Framework for Application is Dangerous and Unlawful in a Quasi-Criminal Proceeding.**

The Department conceded in its opposition that its proposed standard to impose discipline under RCW 18.130.170(1) is inherently subjective, and that it believes it needs no “objective” medical opinion or diagnosis whatsoever to take career-ending action against a physician. This approach leads to a dangerous and arbitrary application of this statute. Moreover, the Department’s liberal and ill-defined category of “mental condition” also undermines the stringent due process protections to which doctors are entitled and turns what would otherwise be a clearly proscribed set of rules into a quagmire of uncertainty for doctors.

#### **1. As a Quasi-Criminal Proceeding, the Charging Statute is Subject to Strict Construction, Thus Requiring Unequivocal Standards for Prosecution.**

Medical licensure is a constitutionally-recognized property right that can be diminished only in accordance with due process. *Nguyen*, 144 Wn.2d at 523; *see also Hardee v. State Dep’t of Soc. & Health Servs.*, 172 Wn.2d 1, 13 (2011) (noting the significant investment required to become

a physician). Moreover, the proceedings are considered “quasi-criminal” in nature. *Nguyen*, 144 Wn.2d at 526. As the Washington Supreme Court has made clear, “a professional disciplinary proceeding subjects a medical doctor to grave concerns which include the potential loss of patients, diminished reputation, and professional dishonor.” *Id.* at 521.

Indeed, the Department’s position *that the order will not be expunged from Dr. Neravetla’s record* underscores the gravity of these proceedings. RB 49. Dr. Neravetla will forever be a marked man as a result of this order – one that is based on fatally flawed law and facts.<sup>1</sup>

Given these significant rights and interests at stake, and the quasi-criminal nature of the statute, the charging statute must be strictly construed in favor of the accused. *Wright v. Washington State Dept. of Health*, 185 Wn.App. 1049, \*6 (2015) (“The rule of lenity applies in both criminal and quasi-criminal proceedings...” and “requires that where two

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<sup>1</sup>The Department’s argument that Dr. Neravetla is in compliance with the order so long as he stays away from the State of Washington is farcical. Dr. Neravetla has an order against him that prevents him from practicing medicine. A response that basically tells Dr. Neravetla just to stay away from Washington vastly minimizes the impact of this ruling on Dr. Neravetla. Moreover, the Department’s assertion that Dr. Neravetla needed to submit evidence of the impact on him ignores the common sense reality that it is impossible for a doctor, who has a sanctioning order in a national database, to gain employment. However, Dr. Neravetla did submit a declaration in support of his opposition to the Court’s motion to dismiss stating that he has been unemployed since 2012, despite the fact that he has applied for hundreds of jobs. *See Declaration of Shantanu Neravetla*, ¶¶11-12, filed January 27, 2016.

possible constructions of a statute are permissible, the statute must be strictly construed in favor of the accused.”); *see also In re Cross*, 99 Wn.2d 373, 379 (1983) (a statute that involves the deprivation of liberty is to be construed strictly); *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 499-500 (1982) (“the ordinance is ‘quasi-criminal,’ and its prohibitory and stigmatizing effect may warrant a relatively strict test”); *In re Disciplinary Proceeding Against Haley*, 156 Wn. 2d 324, 344 (2006) (concurrency) (in a state bar disciplinary proceeding “the rule of lenity requires strict and narrow construction of an ambiguous penal statute.”).

The Department’s contrary argument for a liberal application is without merit. Not only are Appellant’s arguments not antiquated, as the Department suggests, they are supported even by the Department’s cited case law, *Hardee, supra*, 172 Wn.2d 1. Indeed, this precedent actually *reaffirms* the significant interests at stake in *physician* licensing hearings, as opposed to other types of professional regulation. *Id.* at 8 (“The unique education, investment, and personal attachment of a physician’s license indicates that the physician holds a greater property interest in the license than that of a home child care provider. . . .Our decision in *Nguyen* is distinct from the facts presented by Hardee’s case.”).

The Department’s remaining erroneous argument for liberal

application of 170 is based on misapplication of case law interpreting rulemaking authority of agencies charged with regulating public health and safety, which is not the issue at hand. Additionally, those cases did not implicate the constitutional interests of a regulated individual, e.g. a doctor. *See, e.g., Snohomish Cnty. Builders Assn v. Snohomish Health Dist.*, 8 Wn. App. 589, 595 (1973); *Spokane Cnty. Health Dist. v. Brockett*, 120 Wn.2d 140, 149 (1992). Moreover, both of the Department's cited cases predate *Nguyen*, in which the Washington Supreme Court made clear that licensing proceedings such as the instant one are quasi-criminal proceedings and involve clear, constitutionally-recognized property rights. *See Nguyen*, 144 Wn.2d 516 (2001). Thus, the statute is entitled to strict construction in order to protect those rights and interests. To allow the Department to base sanction under 170 purely on conduct denies Dr. Neravetla notice of the nature of the charges against him and a fair opportunity to defend those charges.<sup>2</sup>

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<sup>2</sup> Even if Dr. Neravetla had been charged under RCW 18.130.180, the alleged conduct – which were not substantiated by reliable evidence – fell far below the types of behaviors that constitute unprofessional conduct as established by precedent. *See Appellant's Opening Brief* at 32-33.

**2. The Statutory Scheme and Relevant Case Law Demonstrate the Legislature’s Intent to Regulate Physicians Who Lack Capacity based on Objective Medical Diagnosis Rather Than Mere Allegations, Much Less Unsubstantiated Allegations, of Disruptive Conduct.**

The Department’s position that it can regulate “conduct” under either 170 or 180 flies in the face of multiple rules of statutory construction, conflates the two statutes, and exceeds the Department’s statutory authority. Indeed, the Department’s assertion that charges under both 170 and 180 can be based “entirely on conduct and expert testimony,” makes the entire statutory scheme meaningless. RB 23. Numerous rules of statutory construction undermine the Department’s argument. *See 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); *In re Estate of Mower*, 193 Wn. App. 706, \*6 (2016) (rule against surplusage requires courts to avoid interpretations that would render superfluous a provision of the statute); and *State v. Roggenkamp*, 153 Wn. 2d 614, 623-24 (2005) (under the principle of *noscitur a sociis*, a single word in a statute should not be read in isolation).

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.

Moreover, the statutory language throughout RCW 18.130.170 and its provisions for compelling mental and physical medical examinations indicates that the legislature contemplated this statute to provide authority for medical license holders with mental conditions that are diagnosable or confirmed by medical assessment. *See, e.g.*, 18.130.170(2)(a)-(d) (license

holder can be required to submit to a mental or physical examination by one or more licensed or certified health professionals). Thus, when read as a whole, the purpose of 170 is to address via unequivocal, clear, cogent, convincing evidence whether a physical or mental condition exists that prevents the capacity to practice medicine.

The Department's 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. 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 to present bogus cases and to harass Ryan (for example alleging his landlord

was spying on him and exposing him to debilitating gasses and substances in the air and water of his apartment). *Id.* at 286. The case was based largely on Ryan’s own court filings demonstrating his delusions.<sup>3</sup>

The allegations in this matter – which were in no way substantiated at the administrative hearing as addressed below – are a far cry from the type of findings demonstrated by *Ryan*. Indeed, unsubstantiated hearsay 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.

**3. Even if the Department or Panel Did Have the Authority to Expand the Definition of “Mental Condition,” Neither “Occupational Problem” nor “Disruptive Behavior” Can Constitute a Sanctionable Condition Under 170.**

Here, none of the terms asserted as a basis for sanction by the Department or Panel are sufficiently defined and/or commonly understood to correlate to a mental condition so as to constitute a “mental condition” as that term is used in 170. As such, should “occupational problem” or “disruptive behavior” be included within the scope of the statute, it is void

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<sup>3</sup> In *Ryan*, his own friends testified that he was mentally unstable. In the instant matter, Dr. Neravetla’s father and sister testified in support of him.

for vagueness, and their inclusion violates Dr. Neravetla's due process rights as there was no prior notice that either of these terms were covered by the statute and/or the subject of hearing. *See Haley v. Medical Disciplinary Bd.*, 117 Wn.2d 720, 739 (1991) (Constitutional vagueness) (citing *Connally v. General Constr. Co.*, 269 U.S. 385, 391 (1926)); *In re Curran*, 115 Wn.2d at 758, 801 P.2d 962) (persons "of common intelligence must [not] necessarily guess at [statute's] meaning and differ as to its application"). Indeed, 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. *Haley, supra*, 117 Wn.2d. at 740. Given the lack of objective and defined terms here, these purposes are wholly unfulfilled.<sup>4</sup>

Indeed, *Haley*, cited by the Department – and which notably was brought under 180 to regulate *conduct* – actually supports Dr. Neravetla's position regarding vagueness in this matter. In *Haley*, a surgeon was sanctioned for committing unprofessional conduct after having a sexual

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<sup>4</sup> The record is replete with evidence of the evolving arguments of the Department utilizing the novel and unsupported disruptive behavior arguments, and Dr. Neravetla's attorneys' attempts to respond. *See, e.g.*, AR 1853, ll 24-25 (presiding officer noting that the case was "subtle and somewhat difficult to understand." which by definition means the Department did not have unequivocal, clear, cogent, convincing evidence); *see also* AR 1716-20 and AR 1737-39 (attorneys attempts to address disruptive behavior assertions).

relationship with a minor teenager who was a former patient.<sup>5</sup> *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.

This is not the case with any of the terms here. Importantly, in *Hayley*, the term at issue – “moral turpitude” – *was in the statute itself*. Here, the Department is arguing that terms found nowhere in the statute (“occupational problem” and “disruptive behavior”) are both sufficiently defined and related to terms that *are* in the statute (“mental condition”) that they can be regulated. Nothing could be further from the case.

Notably, although the Department spends much of its brief arguing for coverage of “disruptive behavior,” the Panel itself *did not* rule that Dr. Neravetla engaged in “disruptive behavior.” Instead, it arbitrarily discussed that Dr. Neravetla had an “occupational problem” that “was disruptive to his internship.” However, the notion of an “occupational problem” fails to establish any “mental condition” under 170. The evidence from the witnesses at hearing, including the State’s witnesses,

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<sup>5</sup> Again, a far cry from the nature of the unsubstantiated allegations here.

showed that there is not a commonly understood definition of this term that constitutes a “mental condition”:

- Dr. Mulvihill (State’s witness) testified that to the extent that she noted an “occupation problem” that only meant that there was a problem at the hospital. No clinical determination was made by Dr. Mulvihill in that regard. AR 2320-21, ll 25-5; AR 2320; AR 2323; *see also* AR 2320; AR 2323.
- Dr. Eth (Dr. Neravetla’s witness; quintuple-boarded Professor of Psychiatry; Training Program Medical Director) testified that the Pine Grove evaluation includes an “occupational problem,” which is noted for anybody who is fired from a job and does not constitute a medical diagnosis. AR 2657.
- Dr. Skodol (Dr. Neravetla’s witness and a leading expert regarding the DSM, who is one of its authors) testified that in the DSM IV “there wasn't a whole lot of guidance as to what could constitute an occupational problem....it said examples include job dissatisfaction and uncertainty about career choices.” AR 2676, ll 7-6.

Thus, an “occupational problem,” is simply some problem at work. This is too indefinite and insubstantial to constitute a “mental condition” subject to sanction.

While the Department asserts that the phenomenon of “disruptive

physician behavior” – which was *not* specifically found by the Panel – is well understood by the community, it offers no authority or credible evidence that this is considered in the medical community to be a “mental condition,” much less a mental condition subject to professional sanction.<sup>6</sup>

In fact, the *opposite*, is true. The MQAC Policy Statement relied on by the Department throughout the administrative proceeding *distinguishes between* disruptive behavior and a mental condition, “disruptive behavior may be a sign of an illness or condition that may affect clinical performance.” AR 1833. The Department simply ignores this compelling statement in its own policy guidance.

Moreover, 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. Had the Department intended “disruptive behavior” to be actionable under 170, it certainly should have stated that in the policy document.

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,

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<sup>6</sup> The Department cites *Leal v. Secretary, U.S. Dept. of Health and Human Services*, 620 F.3d 1280, 1283-84 (11th Cir. 2010). While this case describes the attempt to regulate disruptive physician behavior, nowhere in this opinion does the court conclude or even equate disruptive physician behavior to a mental condition.

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. 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. RB 12. Thus, under the Department’s position, 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.

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:

- Dr. Mulvihill (State’s witness) testified that “disruptive behavior” is *not* a “mental condition,” and is just a “descriptive label.” AR 2329, ll 1-12; AR 2325, ll 19-23.
- Dr. Meredith (State’s witness) testified that while others have

“tried” to define it, it could be any variety of behaviors. AR 2203, ll 6-19.<sup>7</sup>

- Dr. Anderson (State’s witness) testified that there are no standard measures for “disruptive behavior.” AR 2258, ll 5-12. Ninety-nine percent of the analysis for “disruptive behavior” comes from collateral reporting. AR 2291, ll 6-15.
- Dr. Skodol (Dr. Neravetla’s expert) testified that evidence of disruptive physician behavior does not establish the existence of any personality disorder or condition. AR 2364.
- Dr. Veltman (Dr. Neravetla’s expert on his petition for reconsideration) stated that the term “‘disruptive physician’ is only descriptive of behavior or a series of behaviors unless and until such time as the subject physician is diagnosed with a psychiatric disorder, at which time the term can be interpreted to also reflect a mental condition.” AR 1628-29.

Even the Department’s attorney conceded at hearing that “disruptive behavior” is not necessarily a “mental condition.” AR 1861, ll 7-22.

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<sup>7</sup> The Department takes issue with Appellant’s assertion that Dr. Meredith testified that “disruptive behavior” is not a condition. Dr. Meredith testified as follows: “Q: Does ‘disruptive behavior’ in quotes constitute any sort of mental condition, constitute a mental condition?” A: I don't believe it is a diagnosis.” AR 2209, ll 9-12. Even if Dr. Meredith were referring to the DSM, as the Department asserts, that argument demonstrates the fine parsing that the Department engages in to attempt to define “disruptive behavior” as a mental condition.

Thus, absent any testimony or authoritative document that suggests that “disruptive behavior” constitutes a mental condition or is even clearly defined, and despite testimony and documents that say in fact the opposite, the Department nevertheless erroneously asks this Court to hold that this ambiguous concept of “disruptive behavior” is subject to sanction as a mental condition under 170. This type of unfettered expansion of the statute is not just unwarranted and without basis, but even more gravely leads to dangerous and arbitrary application of this sanctioning statute.

**B. The Department’s Assertions as to Dr. Neravetla’s Behavior Are Not Supported by the MQAC Decision Which Made *No* Findings About His Behavior at Work, Much Less Findings that He Was Unable To Practice with Reasonable Skill and Safety; Nor is there Substantial, Reliable, Unbiased Evidence in the Record of the Alleged Behavior.**

Even were “disruptive behavior” chargeable under 170, the Panel actually found no evidence of such behavior here. Pursuant to WAPA, the court reviews the evidence submitted to determine whether it constituted substantial evidence sufficient “to persuade a fair-minded person of the truth of the declared premises” to support the factual findings of the agency. *Ames v. Washington State Health Dept. Medical Quality Health Assurance Com’n*, 166 Wn.2d 255, 261 (2009); RCW 34.05.570(3)(e); *Heinmiller v. Dept. of Health*, 127 Wn.2d 595, 607 (1995) (internal quotation marks omitted) (quoting *Nghiem v. State*, 73 Wn. App. 405, 412

(1994)).<sup>8</sup> Moreover, *Nguyen* made clear that the proof in matters such as this is subject to the “unequivocal, clear, cogent, convincing evidence” standard. *Nguyen*, 144 Wn.2d 516, 531 (2001). The evidence here was a far cry from unequivocal, clear, cogent, and/or convincing.

Given the lack of reliable, first-hand accounts as to Dr. Neravetla’s performance, the MQAC Panel made no findings regarding performance specifically stating *it was not making findings* as to Dr. Neravetla’s conduct during his first year of residency. AR 1604, ¶1.3. Indeed, the Panel’s decision specifically noted that much of the testimony about what actually happened during Dr. Neravetla’s residency was “conflicting” and “much of it hearsay.” AR 1604.

Notably, not a single person who had actually worked with Dr. Neravetla when he was working with patients or on the hospital floor testified at the hearing, which was wrongfully focused on his *conduct*. Instead, the only testimony regarding his conduct at work came from:

- Dr. Keith Dipboye, the residency program supervisor, who only

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<sup>8</sup> The Department misstates the relevant standard of review for a challenge based on a lack of “substantial evidence,” claiming “[e]vidence will be viewed in the light most favorable to ‘the party who prevailed in the highest forum that exercised fact-finding authority.’” RB 32, *citing City of University Place v. McGuire*, 144 Wn.2d 640 (2001). However, *City of University Place* is a case reviewing a city’s denial of a land use permit and later administrative process where a hearing examiner reversed the city’s denial. This case was reviewed in the Washington courts under the Land Use Petition Act and not under the Washington Administrative Procedure Act.

alleged he had secondhand reports of Dr. Neravetla's performance, and who at the time of the licensing hearing was also a named Defendant in a federal lawsuit brought by Dr. Neravetla; and

- 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, and who received all of his background information from Dr. Dipboye, but who described Dr. Neravetla's interactions with patients as "unremarkable" and, on occasion, "very nice." AR 2074, ll 21-25.<sup>9</sup>

With the exception of Dr. O'Connell, the Panel did not rely on any of this testimony, other than to find that Dr. Neravetla had "difficult relationships with some of his supervisors." AR 1604, ¶1.3. The Department's assertion that Dr. Dipboye's testimony was corroborated by other witnesses is unsupported by the record and utterly nonsensical. A review of the record demonstrates that the Department presented no reliable, unbiased, first-hand evidence as to whether Dr. Neravetla can actually practice with reasonable skill and safety. The other witnesses

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<sup>9</sup> Following a marked pattern in this case, both by the Panel and the state's witnesses, the Panel relied on Dr. O'Connell's negative testimony but seemingly ignored the positive information about Dr. Neravetla.

based their opinions and testimony primarily on second-hand information from Dr. Dipboye. *See*, AR 2287-88, ll 24-13 (Dr. Anderson confirming that the only negative collateral information came from WPHP and Dr. Dipboye); AR 2327, ll 14-24 & AR 2323-24 (Dr. Mulvihill confirming that she relied on collateral information from Dr. Anderson and Dr. Sherman); AR 2114, ll 3-25, AR 2115, ll 1-7, AR 2120, ll 2-5, AR 2158, ll 6-19, AR 2162-63, ll 24-7 (Dr. Meredith confirming that collateral information came from Virginia Mason and Dipboye). Absent Dr. Dipboye – who the Panel specifically discounted based on his lack of first-hand information – there would be no case.

Thus, the Department’s assertions in its brief that Dr. Neravetla was late, did not respond to pages, etc., are false and wholly unsupported by the Panel’s findings and are completely unsupported by the record. Significantly, the Panel made no findings as to what occurred during Dr. Neravetla’s residency at Virginia Mason and there was no reliable evidence to establish Dr. Neravetla failed to act with reasonable skill and safety. This complete lack of evidence stands in stark contrast to cases like *Ryan*, where significant mental problems unequivocally harmed his work.

Importantly, those who did work with Dr. Neravetla, including Dr. John Roberts, were erroneously excluded from testifying at the hearing about their positive experiences with Dr. Neravetla, including that he was

“excellent;” that his supervisor “enjoyed working with him” on a “very demanding, ICU rotation;” that “nursing staff liked him, and he was respectful to them;” and that he was “reliable, pleasant, personable, engaged, intelligent, very capable.” *See* AR 513; and AR 733-35.<sup>10</sup>

**C. Because There Was No Reliable Evidence Regarding Dr. Neravetla’s Behavior at Work, The MQAC Panel Could Not Legitimately Rely on The State’s Experts Who Based Their Testimony on The Same Unreliable Information.**

In addition to its dangerous and fatally flawed legal basis, the Department’s order is arbitrary, capricious, and unsupported by substantial evidence in light of the whole record, justifying reversal. WAPA, RCW 34.05.570(3) (e) and (i); *Olmstead v. Dep’t of Health, Med. Section*, 61 Wn. App. 888, 891–92 (1991) (reversing suspension of license where it was not supported by substantial evidence).

As noted above, the Panel specifically did not make a ruling as to what happened during Dr. Neravetla’s residency. However, the State’s witnesses who “assessed” Dr. Neravetla – including Dr. Meredith, Dr. Mulvihill, Dr. Anderson, and Jason Green – and who were the bedrock of the Panel’s decision *all relied on the same flawed information* that was expressly rejected by the MQAC Panel in its ruling. The State’s witnesses

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<sup>10</sup> Contrary to the Department’s assertion, Dr. Roberts testimony squarely met the definition of rebuttal in the sense that it would have contradicted the negative collateral information relied on by the State’s witnesses. Despite this, the Presiding Officer excluded it. AR 2363-2366.

all testified that their assessments were based primarily on collateral information that was provided largely by Dr. Dipboye, which was passed on to WPHP. AR 2327, ll 14-24 (Dr. Mulvihill testified her assessment was based on collateral information); AR 2323-24 (same); AR 2287-88, ll 24-13 (Dr. Anderson stating that the *only* negative information in the collateral section of the Pine Grove report came from WPHP and Dr. Dipboye); *see also* AR 2291, ll 6-15 (99% of analysis from collateral information); AR 2307-08, ll 25-4 (same); AR 2114, AR 2115, AR 2120.

To the extent any of the collateral information about Dr. Neravetla was positive, these witnesses – and ultimately the panel – arbitrarily discounted it. *See, e.g.* AR 1826 (Pine Grove Report: “It should be said that collateral information was mixed, with “the five collateral sources suggested by Dr. Neravetla [saying he] was essentially problem free.”).

Moreover, the Panel wrongfully discounted Dr. Neravetla’s preeminent experts, who did objective and independent evaluations, because it wrongly claimed they were focused on ruling out “disorders.” However, all three of Dr. Neravetla’s experts presented at hearing unequivocally stated that he had no disorder *or condition* that would render him unsafe to practice medicine, and they further concluded that Dr. Neravetla 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.<sup>11</sup> *See* AR 2651-55 (Dr. Eth reviewed Pine Grove assessment and WPHP informal evaluation, depositions of Drs. Anderson and Mulvihill and conducted in-person psychiatric evaluation); AR 2633-34 (Dr. Skodol reviewed Pine Grove evaluation); AR 2608-2612 (Dr. De Marchis administered psychological testing to Dr. Neravetla and reviewed Pine Grove report).

Although the Department and the Panel attempted to wrongfully skew Dr. Eth's testimony, Dr. Eth squarely testified that Dr. Neravetla was safe to practice medicine and had no disqualifying condition:

Q: Do you have an opinion as to whether or not he has a mental condition when you evaluated him a few months ago?

A: I did not diagnose any mental condition.

Q: And do you have an opinion within a reasonable degree of medical certainty as to whether or not Dr. Neravetla has any mental condition that would impair his ability to practice medicine skillfully and safely?

A: He does not have any such condition.

AR 2661, ll 2-9. This unequivocal statement of fitness to practice

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<sup>11</sup> Thus, in contrast to the Department's argument, they had access to the same collateral material as the State's witnesses, to the extent such material is relevant.

medicine puts to rest any doubts as to Dr. Eth's opinion. Despite this unequivocal evidence that Dr. Neravetla *did not* have a mental condition rendering him unable to practice medicine, the Panel erroneously and arbitrarily ignored these expert opinions.

**D. The Presiding Officer Should Have Removed the Former Employee of Virginia Mason to Avoid at Least the Appearance of Unfairness.**

Finally, the use of improper procedure by the agency constitutes grounds for reversal of an order.<sup>12</sup> RCW 34.05.570(3) (c). Here, one of the panel members in this matter was a former, longtime employee of the hospital at issue, who knew two of the witnesses professionally, and had even been a colleague in surgery with at least one of them. AR 1887, II 1 - 1888, II 7. That alone should have been enough to remove him from the panel. In addition, Dr. Neravetla at the time of the hearing was engaged in active litigation against this same hospital, and the Presiding Officer was well aware of this. AR 189-217. Thus, any appearance of unfairness was exacerbated by allowing an employee panel member with professional ties to that same hospital to remain on the panel.

The Presiding Officer's superficial inquiry to Dr. Green in no way satisfies the obligation to have a fair and impartial panel and to avoid any

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<sup>12</sup> To the extent any specific argument in Appellant's opening brief is not addressed here, Appellant does not waive any such discrete arguments; rather he stands on his original arguments.

*appearance* of unfairness. The Presiding Officer simply asked Dr. Green whether he could be fair and allowed Dr. Green to decide for himself whether he could be an unbiased decisionmaker. AR 1888, ll 1-7. At a minimum, the Presiding Officer should have conducted an independent inquiry and independent assessment of Dr. Green's ability to be impartial and/or allowed Dr. Neravetla's attorneys to inquire further. AR 1184-85 (counsel requesting a more thorough process).

### **III. Conclusion**

For the foregoing reasons, Dr. Neravetla respectfully requests that this Court entirely overturn the Panel's decision, rescind the sanctions imposed on Dr. Neravetla, and award maximum relief allowed by law.

Dated this 25<sup>th</sup> day of July, 2016.

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**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.

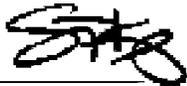
2. I caused to be served upon counsel of record at the address and in the manner described below, on July 25, 2016, the following document: Appellant's Opening Brief.

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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 25<sup>th</sup> day of July, 2016.

  
\_\_\_\_\_  
Shawna L. Parks

**LAW OFFICE OF SHAWNA L. PARKS**

**July 25, 2016 - 3:21 PM**

**Transmittal Letter**

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**Comments:**

Attached is Appellant's Reply Brief for filing.

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