

Case No. 48394-7-II

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

SHANTANU NERAVETLA, M.D.,

Appellant,

v.

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

Respondent.

APPELLANT'S OPENING BRIEF

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I. Introduction

Dr. Shantanu Neravetla was a rising star when he began his transitional year residency at Virginia Mason Medical Center after graduating from medical school. The unwarranted filing of charges against him by the Washington State Medical Quality Assurance Commission (MQAC) dramatically derailed his career.

MQAC charged Dr. Neravetla under a statute that requires a showing via clear and convincing evidence that he is unable to practice medicine with reasonable safety or skill *as a result of a mental condition*. RCW 18.130.170(1).

Notably, four esteemed, independent experts have found that Dr. Neravetla is fit to practice medicine. Neither the Washington Physician's Health Program (WPHP), where he was erroneously referred by Virginia Mason Medical Center, nor the Pine Grove Behavioral Health, where he was referred by WPHP, diagnosed him with a disqualifying mental condition.

Nevertheless, the MQAC Panel – discounting the testimony of all of Dr. Neravetla's expert witnesses – sustained the charges and sanctioned Dr. Neravetla. To reach this conclusion, the Department erroneously shifted the proceedings to focus the hearing on Dr. Neravetla's alleged *conduct*, making the unprecedented and unsubstantiated argument that Dr.

Neravetla had “disruptive behavior” which constituted a mental condition. This is clearly wrong as a matter of law and fact. It also creates an amorphous and dangerous standard that will subject physicians to charges for an unlimited range of activity, and improperly conflates the requirements of RCW 18.130.170, which regulates physicians with “mental conditions,” and RCW 18.130.180, which regulates “unprofessional conduct.”

Moreover, there was not any legitimate evidence of “disruptive behavior,” even if that were a sound basis for a charge under RCW 18.130.170(1). *All* of the witnesses who testified for the Department of Health relied on unverified or disputed collateral information, which was primarily – if not exclusively – hearsay, and sometimes double or triple hearsay. The only first person account of Dr. Neravetla’s behavior came from Dr. Neravetla himself, and he consistently refuted the allegations against him. No one who had worked directly with Dr. Neravetla testified.

As a result, the MQAC’s decision itself is internally inconsistent. First, the Panel noted that it was *not* making findings about what had happened during Dr. Neravetla’s residency because the testimony was conflicting. Nevertheless, it then found that Dr. Neravetla had engaged in “disruptive behavior” that interfered with his residency. It is legal error for

the Panel to decide both that it has insufficient evidence to determine what actually happened and then that Dr. Neravetla's behavior merited sanction.

The MQAC Panel also crafted an unconstitutional sanction with which Dr. Neravetla cannot comply. The Panel ordered that should Dr. Neravetla – who is from Ohio and who returned to Ohio in 2012 – ever return to practice medicine in Washington, that he submit to an assessment by WPHP and follow whatever they recommend. However, Dr. Neravetla cannot get any medical job because of this action on his record, and he has no plans to move back to Washington even if he could get a job as a doctor. As a result, the order will remain in effect in perpetuity continuing to prevent him from getting *any* job in the medical field.

Put simply, the MQAC wholly failed to establish a mental condition that rendered Dr. Neravetla unfit to practice medicine. It then exceeded its authority by moving beyond the charging statute when the original allegations of a mental condition could not be established. Even that case is premised on inherently unreliable collateral information.

Finally, the Presiding Officer made numerous errors throughout the case, including but not limited to allowing a former employee of the involved hospital to remain on the panel, thus violating the appearance of fairness doctrine.

Much more is required of MQAC before it ends a promising physician's career. Anything less undermines the stringent requirements for this quasi-criminal proceeding that subjects a medical doctor to "grave concerns which include . . . diminished reputation, and professional dishonor." *Nguyen v. Dept. of Health*, 144 Wn.2d 516, 521 (2001).

II. Assignments of Error

The Panel made the following errors in finding against Dr. Neravetla:

1. Multiple experts found Dr. Neravetla fit to practice medicine, and there was no evidence of a diagnosis that Dr. Neravetla suffered from a mental condition, which must be proven via clear and convincing evidence in order to sustain charges under RCW 18.130.170.

2. The MQAC Panel relied on unsubstantiated and/or disputed alleged evidence of "traits," "problems," and/or "disruptive behavior," none of which constitute a "mental condition" under RCW 18.130.170.

3. The MQAC Panel conflated the requirements of RCW 18.130.170, which addresses mental conditions, with RCW 18.130.180, which regulates unprofessional conduct.

4. If "disruptive behavior" is a sufficient basis under RCW 18.130.170, the statute is unconstitutionally vague.

5. To the extent “disruptive behavior” is sufficient to sustain charges under RCW 18.130.170, such behavior must be proven by clear and convincing evidence, which was lacking here, as there is no legitimate evidence of disruptive behavior by Dr. Neravetla.

6. The Panel’s decision was internally inconsistent in that it determined both that there was insufficient evidence to decide what actually occurred during Dr. Neravetla’s residency, but also that Dr. Neravetla engaged in “disruptive behavior” that interfered with his residency based on that same information.

7. The Panel’s sanction is conditioned on impossible and/or highly unlikely events, making it impossible for Dr. Neravetla to comply with its terms, and resulting in the action being listed on his record in perpetuity, violating Dr. Neravetla’s due process rights.

In addition, the Presiding Officer made a number of errors, including:

1. Not excluding a former employee of Virginia Mason Medical Center, who said he knew at least one of the witnesses, from the Panel;

2. Not granting summary judgment when there was unrefuted proof that Dr. Neravetla was mentally fit to practice medicine;

3. Not excluding a wealth of unreliable hearsay testimony and/or not allowing such testimony to be probed and/or rebutted.

4. Not allowing Dr. Neravetla to present evidence regarding his behavior and performance at Virginia Mason through knowledgeable witnesses, including those who worked directly with him, including as rebuttal witnesses.

The Superior Court made an error of law when it found that RCW 18.130.170(1) allowed for the MQAC's unsupported definition of "mental condition," and also erred in finding that there was substantial evidence in the administrative record to support the Commission's findings of fact.¹

III. Statement of Facts

A. Background on Dr. Neravetla's Residency and the Events Leading to This Appeal.

Dr. Neravetla was a 26 year old Indian American physician when he began his residency in 2011. Prior to the onset of his transitional year residency at Seattle's Virginia Mason Medical Center ("VMMC") in the summer of 2011, it is undisputed that Dr. Neravetla led an exemplary life of uninterrupted achievement. He received his undergraduate degree magna cum laude from the University of Miami. Administrative Record ("AR") 1055; AR 1813. Petitioner continued to shine in medical school, graduating with countless honors at the University of Louisville School of

¹ The Superior Court's ruling is largely irrelevant at this stage because it did not articulate any separate bases for its decision. Dr. Neravetla includes the Superior Court in the assignments of error to be clear that he also objects to the Superior Court's upholding of the original decision.

Medicine in 2011. AR 1813; AR 2369; AR 2371. In both college and medical school he had an extensive history of volunteerism and awards. AR 2371-72; AR 2449.

During Dr. Neravetla's senior year of medical school, he matched into the highly-competitive and prestigious ophthalmology residency program at the Kresge Eye Institute in Michigan, subject only to his prior completion of a one-year transitional year of general residency at a hospital of his choosing. AR 1813; AR 2345.

Dr. Neravetla matched into VMMC Transitional Year (TY) Residency Program, which was directed by Virginia Mason's employee Dr. L. Keith Dipboye, toward satisfaction of Kresge's precondition. AR 2454. He began his VMMC residency on June 24, 2011. AR 2455. Incident to his residency at VMMC, Dr. Neravetla was granted a limited (one-year) license to practice medicine within the State of Washington as a resident physician and surgeon on June 24, 2011. AR 3.

Within only one month of his arrival at VMMC, Dr. Neravetla became a wrongfully marked man. There is no dispute that Dr. Neravetla's residency proceeded, and ultimately ended, disastrously. However, *why* this occurred is the subject of enormous dispute, and ultimately federal litigation, as all allegations about Dr. Neravetla were funneled through Dr. Keith Dipboye, the supervisor of the Transition Year Residency

Program, and are strenuously disputed by Dr. Neravetla. *See Neravetla v. Virginia Mason Medical Center, et al.*, Ninth Circuit Court of Appeals, Case No. 15-35230 (pending).

Moreover, Dr. Dipboye engaged in disruptive behavior *vis a vis* Dr. Neravetla, including having a profanity-laced first meeting with Dr. Neravetla in July of 2011. AR 2466-2669. Indeed, Dr. Neravetla was “scared” about what was going on with Dr. Dipboye from the outset. AR 2483.

Ultimately, Dr. Dipboye and VMMC wrongfully issued a mandatory referral for Dr. Neravetla to the Washington Physicians Health Program, and sent a file of alleged negative, collateral information without providing any corresponding positive information about Dr. Neravetla. Dr. Charles Meredith and Richard “Jason” Green at WPHP “informally assessed” Dr. Neravetla largely based on this unverified and/or disputed collateral information and referred him for further assessment, which was ultimately conducted by Pine Grove, in Hattiesburg, Mississippi.² AR 1293-94; AR 2108-09; AR 21-15; AR 2120; AR 2133; AR 2158; AR 2162-63.

² There is growing scrutiny of physician health programs (PHPs). *See Physician Health Programs: More Harm Than Good? State-Based Programs Under Fire*, Medscape.com, 2015, CP 307 (noting “there is no real oversight and regulation of these programs...Called by turns coercive, controlling and secretive, with possible conflicts of interest....”).

After the referral, Dr. Neravetla wrote an appeal letter to the CEO of VMMC, asking that the WPHP referral be expunged. AR 2166; AR 2422. An investigation into what Dr. Neravetla had told them occurred was promised by the CEO of VMMC, but was never conducted. AR 2423; AR 2530-31. Having no substantive response from the hospital, Dr. Neravetla ultimately reluctantly reported to Pine Grove. AR 2531.

In May, 2012, Dr. Neravetla reported to Pine Grove for evaluation. Pine Grove conducted assessments of Dr. Neravetla, including by Ed Anderson, Ph.D., and Teresa Mulvhill, M.D. Pine Grove did not diagnose Dr. Neravetla with anything. Rather it suggested incorrectly that he had obsessive compulsive and narcissistic personality “traits” and mentioned “disruptive behavior.” AR 2327; AR 2323; AR 2320. However, neither “traits” nor “disruptive behavior,” even if true, rise to the level of a diagnosable condition. AR 1371; AR 2325; AR 2204; AR 2209; AR 2364; AR 2657; AR 2661. Pine Grove again relied on the same flawed collateral information that was forwarded by WPHP in order to attach this label. AR 1817-19; AR 2327; AR 2323-24; AR 2291; AR 2307-08.

Pine Grove stated in its report that it does not determine fitness for duty. Despite not finding any diagnosable condition it opined that Dr. Neravetla should undergo six weeks of intensive, in-patient therapy – at

the cost of several tens of thousands of dollars – followed by long-term monitoring and possible further counseling. AR 1801-30.

On March 26, 2012 WPHP reported Dr. Neravetla to the Washington State Department of Health, Medical Quality Assurance Commission (MQAC) because it was allegedly unaware he had reported to Pine Grove for assessment. AR 1799.

Dr. Neravetla was subsequently terminated from the VMMC Transitional Year Residency Program as a result of his alleged refusal to comply with WPHP. He also lost his ophthalmology residency slot at the Kresge Institute. During that process, VMMC held a grievance hearing, during which numerous doctors testified in support of Dr. Neravetla. AR 2384; AR 2430; AR 2225-30.

Dr. Neravetla's one-year license expired of its own accord on July 31, 2012. AR 3. Dr. Neravetla left Washington and moved home to Ohio.

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.³ AR 3-6.

³ RCW 18.130.170(1) is incorporated within Washington's formulation of the Uniform Disciplinary Act. The Act basically permits two circumstances when a physician may be subjected to discipline. *See* RCW

On May 20, 2014, the MQAC issued legally unsupported and arbitrary and capricious Findings of Fact and Conclusions of Law that upheld the charges and issued sanctions against Dr. Neravetla. AR 1601-14.

Dr. Neravetla has not practiced medicine in Washington, or any other state, since being terminated from VMMC. The MQAC Final Order is reportable to the National Practitioners Data Bank (NPDB) as an “adverse action” and remains on his record. *See* §6403 of the Affordable Care Act of 2010, 42 U.S.C. §1396r-2.

As Dr. Neravetla has explained, “[b]ecause of the MQAC proceedings and the allegations against me, it has been impossible for me to gain entry to any residency program in furtherance of my career. Nor have I been able to obtain employment within the health care field or related fields.” Clerk’s Papers (CP) 66. In effect, this decision terminated Dr. Neravetla’s career before it even began.

18.130.160. One circumstance relates to a physician’s *mental condition* as charged here. The other circumstance relates to the physician’s *conduct* (18.130.180(1)-(25)).

B. Administrative Proceedings Charged Dr. Neravetla with Having a “Mental Condition” that Rendered Him Unsafe to Practice Medicine.

The MQAC’s charged Dr. Neravetla under RCW 18.130.170(1). The Statement of Charges at ¶ 1.4 incorrectly alleges that WPHP “diagnosed” Dr. Neravetla as having a “personality disorder.” AR 4. Although the Statement makes mention of “disruptive behavior” in several places, the document clearly charged Petitioner only with a “mental disorder” that impaired his ability to practice medicine with skill and safety. AR 3-6.

Counsel for Dr. Neravetla filed his Answer to the Statement of Charges on May 1, 2013, denying all substantive allegations. AR 19-32. The Answer included the expert opinion of Dr. Charles Walters, a practicing psychiatrist and neurologist, that Dr. Neravetla was fit for duty.⁴ *Id.*

⁴ On July 19, 2013, counsel for Dr. Neravetla filed a Motion to Dismiss for Lack of Jurisdiction because Dr. Neravetla’s temporary license had expired. AR 76-102. That Motion was denied by the ALJ on August 8, 2013. AR 157-60.

C. Dr. Neravetla Submitted Multiple Reports From Esteemed Experts and a Summary Judgment Motion Establishing that He Was Fit to Practice Medicine.

In March of 2014, Dr. Neravetla filed a Motion for Summary Judgment, based on expert reports which stated that Dr. Neravetla has never been diagnosed with any mental or physical condition and that he is, in fact, fit for duty. These included the report from Dr. Massimo De Marchis, stating that “I am satisfied to a reasonable degree of professional certainty that Dr. Neravetla does not demonstrate any personality disorder that would adversely affect his fitness to practice medicine;” (AR 1030-32; *see generally* AR 1026-36); the report from Dr. Spencer Eth, stating that: “My own psychiatric evaluation of Dr. Neravetla, of comparable time and scope as the Pine Grove psychiatric examination, establishes that he does not suffer from any mental condition whatsoever...” (AR 1050; *see generally* AR 1040-50); and the report from Dr. Andrew Skodol, stating that “in my professional opinion, the Pine Grove evaluation fails to establish that Dr. Neravetla is unfit for duty...” (AR 1059; *see generally* AR 1054-76).

The motion established through deposition testimony that Dr. Meredith did not diagnose Dr. Neravetla with any mental conditions or disorders, but merely “informally assessed” him (AR 1371, Ll 14-16, 48-

49 (Green Depo.)); and Dr. Anderson made no finding that Dr. Neravetla had a diagnosed mental condition (AR 1371). Instead, Pine Grove suggested that Dr. Neravetla had “traits,” or an “occupational problem,” but even if true, those do not rise to the level of a disorder. AR 1371.

The motion was improperly denied by the Presiding Officer despite the fact that there was no evidence of a mental condition. AR 1533-38. Instead, the Presiding Officer stated that because of the “many questions raised” about Dr. Neravetla’s “odyssey,” there were triable issues of fact. AR 1538.

D. The Pretrial Proceedings Wrongfully Shifted to Focus on Dr. Neravetla’s Alleged “Behavior,” But No New Charges Were Filed.

Following the Presiding Officer’s denial of the Motion for Summary Judgment, the focus of the MQAC proceeding shifted wrongly and abruptly from Dr. Neravetla’s mental health to his alleged “disruptive” conduct at VMMC. However, the Statement of Charges was not amended to charge inappropriate conduct, under RCW 18.130.180, as opposed to an alleged mental condition. The Presiding Officer did not allow more time for discovery to defend against allegations of disruptive behavior. *See* AR 1726, ll 13-16; *see also* AR 2672, ll 20-23 (allegation that the mental condition is that Dr. Neravetla was disruptive in the

workplace). Dr. Neravetla's counsel repeatedly objected to the Department presenting a case about conduct in a matter that was supposed to address whether Dr. Neravetla had a "mental condition," and to the primary reliance on hearsay as to any alleged behavior. AR 1722-32; AR 1739-42; *see also* AR 1865, ll 12-15; and AR 1859, ll 24-25.

E. Testimony and Evidence Presented at the Hearing Itself Failed to Establish the Required Elements Under RCW 18.130.170.

1. All Witnesses At the Hearing Agreed That Dr. Neravetla was not Diagnosed with Anything.

Testimony at the hearing showed that no one had diagnosed Dr. Neravetla with any mental disorder or condition. Dr. Teresa Mulvihill of Pine Grove Behavioral Health, where Dr. Neravetla was referred by WPHP, found that Dr. Neravetla suffered "no psychiatric disorder." AR 2327; *see also* AR 2323, ll 22-25. Dr. Mulvihill established in her testimony that while Pine Grove listed what is known as an Axis I finding, that it merely indicated that Dr. Neravetla had a factual "occupational problem" inasmuch as he had been suspended by VMMC. AR 2320; AR 2323. No clinical determination was made by Dr. Mulvihill in that regard. AR 2320; AR 2323.

Ed Anderson, PhD, of Pine Grove, further confirmed that they did not diagnose any personality disorder, and did not have the evidence to make this diagnosis. AR 2269, ll 5-14; AR 2269, ll 15-25.⁵

Plaintiff's expert, Dr. Massimo De Marchis, examined Dr. Neravetla, administering some of the same tests as those administered by Dr. Anderson. *See* AR 2609-12. Based on the results Dr. De Marchis concluded that Dr. Neravetla "answered the test items in an honest and straightforward fashion." AR 2612. Dr. Neravetla's test results had "very low probability of overly positive self-presentation." *Id.*

Dr. Neravetla's results on the Minnesota Multiphasic Personality Inventory were "entirely within normal limits, suggesting that the client reported no serious psychological problems." AR 2613. In Dr. De Marchis's opinion, Dr. Neravetla seemed to have "no unmanageable psychological conflict or threatening stressors at this time and his personal adjustment appears to be adequate. He seems to be dealing effectively with situational demands." *Id.* His profile was entirely within normal limits and indicative of good adjustment levels. AR 2614.

Plaintiff's expert, Andrew Skodol, M.D., one of the authors of DSM-III, DSM-IV, and DSM V, testified that Dr. Neravetla did not

⁵ Dr. O'Connell testified that he did not do any psychological assessment of Dr. Neravetla, and had only two "coaching" sessions with him. AR 2080, ll 3-5; AR 2094, ll 6-13.

exhibit any personality disorders or mental health conditions based on his review of Pine Grove's report. AR 2633.

Plaintiff's next expert, Dr. Spencer Eth, M.D., a quintuple-boarded training program director, conducted a three and half hour evaluation of Dr. Neravetla. In addition, he reviewed Pine Grove's report. He opined that "Dr. Neravetla does not suffer from a psychiatric[,] substance use or personality disorder and, therefore, does not need any psychiatric treatment." AR 2655, ll 5-7. Moreover, Dr. Eth testified that:

the Pine Grove evaluation failed to provide any reasonable basis for its recommendation that Neravetla ought not to attempt to assume responsibilities as a resident physician until he participates in an intensive residential-level treatment program. That recommendation is without merit and should be disregarded. AR 2655, ll 9-14.

Finally, Dr. Eth concluded that Dr. Neravetla is "currently fit to return to full duty in a postgraduate medical training program." AR 2655, ll 15-17. "[T]here should be nothing psychiatric that would hold him back from resuming his career in a safe and responsible way." AR 2666, ll 9-11.

2. Testimony Showed That “Disruptive Behavior,” Does Not Constitute a “Mental Condition.”

Dr. Mulvihill from Pine Grove candidly testified that “disruptive behavior is a descriptive label, it’s not a diagnosis.” AR 2325, ll 22-23. She further testified that it is also not a mental condition. AR 2329, ll 1-9. To the extent Dr. Neravetla was labeled with an “occupational problem,” that only meant that there was a problem at the hospital. AR 2320-21, ll 25-5. Similarly, Dr. Meredith from WPHP testified clearly that “disruptive physician behavior” is not a diagnosis. AR 2204 ll 7-12; AR 2209, ll 9-12.

As Plaintiff’s expert, Dr. Skodol, explained evidence of disruptive physician behavior does not establish the existence of any personality disorder or condition. AR 2364.

Dr. Eth explained that the Pine Grove evaluation includes a finding of an “occupational problem,” which is noted for anybody who is fired from a job and does not constitute a medical diagnosis. AR 2657. Dr. Eth stated that “traits are not disorders. ...that is not a mental condition that requires treatment.” *Id.*

Dr. Eth did not diagnose Dr. Neravetla with any mental condition and did not think that Dr. Neravetla has any mental condition that would impair his ability to practice medicine skillfully and safely. AR 2661.

F. To the Extent Any Witness Identified “Disruptive Behavior,” It was Based Purely on Unverified and/or Disputed Collateral Information and Hearsay.

The assessments of Pine Grove and WPHP were admittedly primarily based on unverified and disputed collateral information. The Pine Grove report contains a specific disclaimer that “[w]e have not attempted to, assure the accuracy of the collateral information provided.” AR 1828 (emphasis added).

Moreover, as noted in the 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.” AR 1826; *see also* AR 1817-19 (listing collateral information with unattributed quotes). Nevertheless, Pine Grove continued to rely on the negative collateral information.

Dr. Mulvihill from Pine Grove confirmed that based on her assessment of Dr. Neravetla she found “no major psychiatric disorder,” but that “[a]fter finding out the collateral information and meeting with Dr. Sherman and Dr. Anderson,” she believed that he had “disruptive behavior.” AR 2327, ll 14-24 (emphasis added); AR 2323-24.

Dr. Anderson confirmed that the only negative information in the collateral section of the Pine Grove report came from WPHP and Dr.

Dipboye. AR 2287-88, ll 24-13. Moreover, he testified that as much as ninety-nine percent of his analysis is based on collateral reports. AR 2291, ll 6-15; *see also* AR 2307-08, ll 25-4.

Similarly, Dr. Meredith from WPHP stated that he had received information from Mr. Green, who in turn had received information from VMMC. 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.

At the hearing, Dr. Neravetla himself was the only person who testified who had been present for his alleged behavior, and he testified at length to the effect that the allegations against him were false and unfounded. *See* AR 2448-2598.

Moreover, Dr. Neravetla testified that he himself had been the subject of *Dr. Dipboye's* disruptive behavior, which included a profanity-laced first meeting with Dr. Dipboye. AR 2466-67, ll 21-5; *see also* AR 2534-36, ll 20-4. Even Dr. Dipboye acknowledged that he “might” have used foul language during this meeting. AR 2004, ll 6-22.

More than that, Dr. Neravetla was “scared” by this initial meeting, a feeling that only intensified as Dr. Dipboye continued to solicit and disseminate negative information about Dr. Neravetla. AR 2420-21; AR 2482-85; *see also* AR 1787 (noting that Dr. Neravetla had described his first meeting with Dr. Dipboye as “abusive”).

G. The Panel Issued an Internally Inconsistent and Fatally Flawed Decision.

Based on this information, the Panel issued a completely muddled, and arbitrary and capricious decision, without a basis in law, upholding the charges. The order itself reflects the circularity of this case.

On the one hand, the Panel stated that it was making no findings as to Dr. Neravetla's conduct during his residency:

There was conflicting testimony, much of it hearsay, concerning the Respondent'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 Respondent's own admission of missing certain classes, the Commission makes no finding regarding Respondent's conduct during his residency except to note that the Respondent had difficult in relationships with some of his supervisors.

AR 1604, ¶1.3 (emphasis added). The Commission also 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.

Despite making no finding as to what actually happened during Dr. Neravetla's residency, and finding no diagnosed disorder, the Commission nevertheless then ruled that Dr. Neravetla fell within the boundaries of RCW 1.130.170, and acted on his license, finding that "[i]n this case. . . the Commission finds that the Respondent did have an 'occupational problem.'" AR 1607, n.4.

In wildly inconsistent and capricious fashion, the Commission then made conclusions about what *did* happen during Dr. Neravetla's residency as the basis for this occupational problem, stating:

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").⁶

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 seek

⁶ Notably, the MQAC Policy on Disruptive Behavior was not even in effect during the course of Dr. Neravetla's residency, having been adopted after the referral to WPHP. AR 1444-45; AR1479.

evaluation from a WPHP referred evaluator and follow any subsequent recommendations. AR 1612, ¶3.1.

In reaching these conclusions, the Commission summarily dismissed the testimony of *all* of Dr. Neravetla's experts, despite the fact that they are preeminent with unimpeachable qualifications. The Commission erroneously stated that the weight of their testimony was "minimal since their evaluations were aimed at ruling out a psychiatric or personality 'disorder.'" AR 1608, ¶1.9(c). The Commission further confirmed that Dr. Dipboye and Dr. Owens did not have first-hand information about Dr. Neravetla. AR 1608, ¶1.9(c).

Dr. Neravetla sought reconsideration by the Commission, arguing, *inter alia*, that "disruptive behavior" does not constitute a mental condition. AR 1615-24. Dr. Neravetla presented further written testimony from Dr. Skodol, who stated that "'disruptive behavior' or 'disruptive physician behavior' is neither a recognized mental disorder nor a recognized mental condition according to the DSM-IV." AR 1639, ¶6. This request for reconsideration was denied. AR 1777-78.

H. Superior Court Proceedings

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.

IV. Standard of Review

Courts apply the standards of the Washington Administrative Procedure Act (WAPA), chapter 34.05 RCW, directly to the agency record in reviewing agency adjudicative proceedings. *Ames v. Washington State Health Dept. Medical Quality Health Assurance Com'n*, 166 Wn.2d 255, 260 (2009); *William Dickson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 407 (1996) (citing *Tapper v. Employment Sec. Dep't*, 122 Wn.2d 397, 402–03 (1993)). Under the WAPA, a reviewing court 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. RCW 34.05.570(3)(d), (e), (h), (i), (a), (b), (c); *Tapper*, 122 Wn.2d at 402; *Olmstead v. Dep't of Health, Med. Section*, 61 Wn. App. 888, 891–92 (1991).

A decision is arbitrary and capricious if it is willful and unreasoning and disregards or does not consider the facts and circumstances underlying the decision. RCW 34.05.570(3)(i); *Heinmiller*

v. Dep't of Health, 127 Wn.2d 595, 609 (1995); *Alpha Kappa Lambda Fraternity v. Washington State Univ.*, 152 Wn. App. 401, 421 (2009).

When reviewing an administrative agency decision, courts review issues of law de novo. *Ames*, 166 Wn.2d at 261; *Kellum v. Dep't of Ret. Sys.*, 61 Wn. App. 288, 291 (1991) (citing *Franklin Cty Sheriff's Office v. Sellers*, 97 Wn.2d 317, 325 (1982)); *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 728 (1991). Courts can then substitute their judgment for that of the administrative body on legal issues. *Kellum*, 61 Wn.App. at 291; *William Dickson Co.*, 81 Wn. App. at 407.

With regard to issues of fact, the court reviews the evidence submitted to determine whether it constituted substantial evidence to support the factual findings of the agency. *Ames*, 166 Wn.2d at 261; RCW 34.05.570(3)(e). Although medical review boards are able to rely on their own expertise in evaluating medical practices, substantial evidence is that which is sufficient “to persuade a fair-minded person of the truth of the declared premises’.” *Heinmiller*, 127 Wn.2d at 607 (internal quotation marks omitted) (quoting *Nghiem v. State*, 73 Wn. App. 405, 412 (1994)); *Wash. State Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 482 (1983); *Davidson v. Dep't of Licensing*, 33 Wn. App. 783, 785 (1983).

V. Argument

Medical licensure is a constitutionally-recognized property right that can be diminished only in accordance with due process. *Nguyen, supra*, 144 Wn.2d at 523; *see also Hardee v. State Dep't of Soc. & Health Servs.*, 172 Wn.2d 1, 13 (2011) (noting the investment required to become a physician). “A professional disciplinary proceeding subjects a medical doctor to grave concerns which include the potential loss of patients, diminished reputation, and professional dishonor.” *Nguyen*, 144 Wn2d at 521. In medical disciplinary proceedings, the government (the Department of Health) always bears the burden of proof. *Id.* at 528-530. Further, all material facts must be proven by “clear, cogent and convincing” evidence. *Nguyen*, 144 Wn.2d at 529. The Department wholly failed to meet its burden in this case. MQAC’s final determination cannot stand under the rigorous legal standards governing the imposition of conditions and limitations on his right to practice medicine.

A. The MQAC Panel Committed Legal Error by Creating an Unprecedented, Amorphous and Arbitrary Standard for a “Mental Condition.”

The Department argued, and the MQAC Panel incorrectly concluded, that the term “mental condition” should be given an extremely broad and expansive interpretation, such that it would be satisfied by

allegations of “disruptive behavior” or an “occupational problem” alone, without any corresponding diagnosis of an actual mental condition. Specifically, the Commission ruled that a “respondent does not have to have fit into any particular type of diagnostic label peghole to trigger RCW 1.130.170(1). . . . In this case, as indicated, the Commission finds that the Respondent did have an ‘occupational problem’ (a condition) that disrupted his internship.” AR 1607, n.4. This reading of the statute is contrary to the language of the statute itself, and opens the door to limitless licensure actions against physicians who – like Dr. Neravetla – have been found by multiple experts fit to practice medicine.

Given the liberty and property implications of the MQAC proceeding, the controlling statute, RCW 18.130.170(1), must be strictly construed. *See In re Cross*, 99 Wn.2d 373, 379 (1983) (a statute that involves the deprivation of liberty is to be construed strictly) ; *Pac. NW Annual Conf. of United Meth. Church v. Walla Walla Cty.*, 82 Wn.2d 138, 141 (1973) (“given a choice between a narrow, restrictive construction and a broad, more liberal interpretation, we must choose the first option”); *see also Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (statutes that implicate an individual’s liberty must be narrowly construed).

The charging statute states:

[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.

RCW 18.130.170(1)(emphasis added).

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. However, the overall construction of the charging statute assumes that a diagnosis will be at issue. Section RCW 18.130.170 of UDA 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. Moreover, 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). What would reports from certified health professionals address, other than whether he was diagnosed with anything and whether he was mentally fit to practice medicine. This is precisely what his reports established.

Moreover, nothing has changed the requirement that there be some kind of diagnosable condition under RCW 18.130.170, including the MQAC Policy Statement on disruptive behavior. Indeed, that policy itself expects that “disruptive behavior” is not, in itself, a mental condition, stating: “*disruptive behavior may be a sign of an illness or condition that may affect clinical performance.*” AR 1833. Thus, “disruptive behavior” is

not in and of itself an “illness or condition.”⁷ Moreover, this “policy statement” is just that – a policy statement. It is not law, did not amend the charging statute, and did not expand the bases on which doctors can be charged under RCW 18.130.170.

The experts in this case confirmed that “disruptive behavior” is not a diagnosis, but more of a “descriptive label.” Dr. Meredith testified that “disruptive behavior” is not a mental condition and is not a diagnosis. AR 2209; *see also* Veltman L., The Disruptive Physician: The Risk Manager’s Role, *Journal of Healthcare Risk Management*, 1995:15:11 (noting that “disruptive physician,” is only a descriptive term, and used until doctor is diagnosed with a disorder) (AR 1629). As Dr. Anderson from Pine Grove explained, it is not even possible to measure “disruptive physician behavior” through standard psychological instruments because it is not a “standard” mental disorder. AR 2257-58, ll 8-23.

Dr. Neravetla’s expert, Dr. Skodol, testified that evidence of disruptive physician behavior does not establish the existence of a personality disorder or a mental health condition. AR 2634. Dr. Skodol testified that DSM-V, the current guide on mental health conditions and disorders, contains a statement that “Other” conditions and problems,

⁷ Moreover, all of Dr. Neravetla’s interactions and comments recounted by Drs. O’Connell, Meredith, and Anderson and Mr. Green clearly occurred outside of workplace and were not disruptive in the sense ascribed to the term by the MQAC Policy Statement.

listed in the chapter on occupational problems, are not mental disorders.
AR 2645.

To the extent that Dr. Mulvihill found that Dr. Neravetla had obsessive compulsive traits, that is not at all unusual, as she believes that most people who have completed professional degrees, especially medical school, would have obsessive compulsive traits. AR 2321-22, ll 22-13. Indeed, she believes that at least half of first year residents would have obsessive compulsive traits. AR 2323, ll 7-21.

The Transitional Year Residency program was established precisely to guide medical graduates in the nuances and realities of practicing medicine. A new precedent that any physician – who is wrongfully accused of being impaired and who raised complaints in confidence about himself being subjected to persecution and intimidation (disruptive behavior by his superior) – is deemed to be engaged in disruptive behavior, constituting a “mental condition,” will have the effect of essentially silencing dissent and authorizing subjugation based on little more than interpersonal differences in the medical workplace.

B. The Panel Conflated the Requirements of Section RCW 18.130.170, Which Regulates Mental Conditions, and the Requirements of Section RCW 18.130.180, which Regulates Unprofessional Conduct; Dr. Neravetla Was Not Charged Under 18.130.180.

Here, the panel committed legal error by conflating RCW 18.130.170 and RCW 18.130.180. Specifically, the Panel considered evidence and made conclusions that would be appropriate only in a case brought under Section 18.130.180 case.

Notably, Dr. Neravetla was *not* charged under RCW 18.130.180 governing “unprofessional conduct,” nor could he have been, as the record contains no evidence of the required elements for that section, including, *inter alia*, any “act involving moral turpitude, dishonesty, or corruption relating to the practice of the person’s profession,” or “incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.” Nor did any conduct alleged rise to the level that would merit prosecution under this statute. *See Ancier v. State, Dep’t of Health*, 140 Wn. App. 564, 568 (2007) (upholding indefinite revocation of license of doctor who issued 180,000 prescriptions in a three year period without physically examining or personally interviewing any of the persons receiving the prescriptions);

Wright v. Washington State Dept. of Health, 185 Wn. App. 1049 (2015) (upholding sanctions for aiding and abetting unlicensed practice of medicine); and *Olson v. State Dep't of Health, Med. Quality Assurance Cmsn.*, 179 Wn. App. 1035 (2014) (upholding sanction for sexual misconduct with patients).

This conflation is not *de minimus*. Had Dr. Neravetla been charged under the other statute, he would have had a full and fair opportunity to present a defense based on “conduct,” as opposed to any “mental condition.” This was not a harmless error because what Dr. Neravetla prepared for and presented was a case under RCW 18.130.170, to address his fitness to practice medicine as a result of a mental condition. He and his counsel were severely prejudiced by the switch to the focus on his conduct. AR 1716-20; AR 1737-39.

Had he been appropriately apprised that his conduct was at issue he could have elicited testimony from those he worked with about his conduct, who would have related, among other things, that Dr. Neravetla 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 generally* AR 513 (Dr. Skodol account of positive feedback from Dr. Neravetla’s direct supervisors,

including Drs. Roberts, Gadgil, and Gokhale); and AR 733-35 (Pine Grove report account of positive feedback from supervisors). However, because the Commission chose to charge Dr. Neravetla under 18.130.170, Dr. Neravetla prepared and presented his case related to whether he had a “mental condition.”

C. If “Mental Condition” Can Mean Anything, Including Undefined “Disruptive Behavior” The Statute is Unconstitutionally Vague.

The Due Process clause of the Fourteenth Amendment requires that citizens be afforded fair warning of proscribed conduct.⁸ *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

⁸ Dr. Neravetla argued *ad naseum* in both the Administrative Proceedings and Superior Court that the MQAC inappropriately used the wrong standard in this matter. To the extent Dr. Neravetla now raises a constitutional dimension to the MQAC’s flawed ruling, the Court may consider those arguments on this appeal under Rule of Appellate Procedure 2.5(a) and *Roberson v. Perez*, 156 Wn.2d 33, 39-41 (2005) (noting discretionary nature of RAP 2.5).

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).

Further, “the due process clause forbids criminal statutes that contain no standards and allow police officers, judge, and jury to subjectively decide what conduct the statute proscribes or what conduct will comply with a statute in any given case.” *City of Spokane v. Douglass*, 115 Wn.2d 171, 181 (1990) (quoting *State v. Maciolek*, 101 Wn.2d 259, 267 (1984)). Accordingly, the due process clause requires that a penal ordinance provide “minimal guidelines ... to guide law enforcement.” *Douglass*, 115 Wn.2d at 181. Because licensing proceedings are considered quasi-criminal, physicians charged under these statutes deserve nothing less. *See Keene v. Bd. of Accountancy*, 77 Wn. App. 849, 854 (1995) (rules imposing sanctions in professional proceedings may not be unconstitutionally vague).

If a “mental condition” includes “disruptive behavior,” doctors prosecuted under this section can be prosecuted for practically anything. The description of “disruptive behavior” is varied and vague. MQAC’s Policy Statement on Disruptive Behavior lists everything from “difficulty

working collaboratively with others” to “inappropriate chart notes” as examples of disruptive behavior. *See* AR 1833. Given these types of statements, physicians may be charged based on a limitless variety of conduct, without ever being diagnosed with any kind of mental health condition. Physicians will not know whether legitimate challenges to hospital policy, patient care, or other doctors’ behavior will be viewed as disruptive, and therefore subject to charges by the Commission. Because “disruptive behavior” is not diagnosable, as per the State’s own witnesses, it is truly subjective and undefined. This type of regulation is unconstitutionally vague.

Applied the question to this case, assuming *arguendo* there is some truth to any of the unsubstantiated, hearsay allegations – which Dr. Neravetla strongly disputes – Dr. Neravetla could not have anticipated that his license would be acted upon based on allegations of tardiness and unpleasant demeanor, either during his residency or during the hearing itself. *See Maynard v. Cartwright*, 486 U.S. 356, 361 (1988) (non First Amendment vagueness challenges evaluated in light of the facts of that particular case).

As the court in *Nguyen* noted, these proceedings are already subjective, thus requiring exacting standards of proof. *Nguyen, supra*, 144 Wn.2d at 531 (citing *Cf. Tellevik v. Real Property*, 120 Wn.2d 68, 838

(1992) (ex parte probable cause hearing in a civil forfeiture proceeding sufficient to 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.

D. MQAC Violated Dr. Neravetla’s Due Process Rights When the Proceeding Changed from Allegations of a “Mental Condition” to Focus on Conduct.

Dr. Neravetla was prejudiced by the change in allegations from “mental condition” to “disruptive behavior.” “[A]n administrative body must follow its own rules and regulations when it conducts a proceeding which can deprive an individual of some benefit or entitlement.” *Ritter v. Bd. of Comm'rs*, 96 Wn.2d 503, 507 (1981); see also *Lang v. Washington State Dep't of Health*, 138 Wn. App. 235, 252 (2007). The failure of an agency to follow its own procedures establishes a procedural due process violation when the claimant is prejudiced. *Motley–Motley, Inc. v. Pollution Control Hearings Bd.*, 127 Wn.App. 62, 81 (2005). A showing of prejudice is based on the claimant’s inability to prepare or present a defense. *Id.* Due process requires notice of the issues to be raised at a

disciplinary hearing, *In re Ruffalo*, 390 U.S. 544, 551-52 (1968). Here, this is precisely what happened. Although the statement of charges indicated that Dr. Neravetla was potentially subject to sanction based on a “mental condition,” that rendered him unsafe to practice, the proceeding switched to focus instead on Dr. Neravetla’s conduct. While disruptive behavior was mentioned in the statement of charges, it was listed merely as evidence of the “personality disorder,” with which the charges said Dr. Neravetla had been diagnosed. This change in emphasis prejudiced Dr. Neravetla in numerous ways, including the witnesses he would have called and the evidence he would have presented.

There was substantial discussion at the pretrial conference about this change. Even the Presiding Officer at the outset of the hearing noted that the case was “subtle and somewhat difficult to understand.” AR 1853, ll 24-25.

This change prejudiced Dr. Neravetla in numerous ways. Importantly, the Presiding Officer took the position that Dr. Neravetla was barred from making use of any documents or testimony that were not identified in Dr. Neravetla’s Prehearing Memorandum.

The Memorandum was filed on March 26, 2014, at which time Dr. Neravetla’s Motion for Summary Judgment was pending before the Presiding Officer. Counsel for Dr. Neravetla’s received a copy of the

Presiding Officer's Prehearing Order No. 10, denying Respondent's Motion for Summary Judgment on April 2, 2014. At the Prehearing Conference held on April 7, 2014, counsel for Dr. Neravetla (a) requested an extension of the hearing date to permit an opportunity to conduct further discovery on the newly-alleged claim of disruptive behavior on the part of Neravetla, and (b) indicated that he intended to find additional witnesses and documents to defend against the newly-alleged disruptive behavior claims. *See* AR 1716-20; AR 1737-39. The Presiding Officer ruled against any extension. *Id.*

Due to the restrictive evidentiary position taken by the Presiding Officer, Respondent was precluded from offering numerous exhibits and testimony, including testimony by former supervisors and colleagues, all to quash the baseless disruptive behavior allegations.

E. There Was No Legitimate, Much Less Substantial, Evidence Presented That Dr. Neravetla Could Not Practice With Reasonable Skill and Safety.

Further, the Department presented no evidence as to whether Dr. Neravetla can actually practice medicine with reasonable skill and safety, and the Panel made no findings as to what actually happened during Dr. Neravetla's residency. There were no allegations that Dr. Neravetla had injured a patient or that any specific patient was ill-treated or under threat.

Instead, the focus was on allegations regarding Dr. Neravetla's behavior, attendance, and responsiveness to being paged. Even the Department's own characterization of Dr. Neravetla's behavior was merely that "he was often late, had unexcused absences, and had difficulty accepting constructive criticism." CP 270, 11:1-2 (Department's Responsive Brief).

Should the Department rely on the Patient Safety Alert (PSA), the Department is fundamentally distorting the nature of that process. PSAs are learning tools which are meant to improve a particular hospital process, and employees are actively encouraged to file them. To that end, approximately, 5,000 PSAs are filed each year at VMMC. AR 1960-61.

In this case, as argued above, there is no evidence that Dr. Neravetla had or has a "mental condition." But even if there were, there is no evidence that he was unable to practice medicine with reasonable skill and safety. No substantial evidence exists to support this case.

**F. The Panel Relied on Information that It Determined Was
Conflicting and Unreliable Hearsay to Support Its Ruling
Regarding Alleged Disruptive Behavior.**

The Panel's decision was arbitrary and capricious because it both found there was insufficient evidence to make a determination as to what actually happened during Dr. Neravetla's residency, and then found –

based on that same information – that Dr. Neravetla had engaged in disruptive behavior during his residency. 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. However, the state’s witnesses – including Dr. Meredith, Dr. Mulvihill, Dr. Anderson and Jason Green, *all relied on that same flawed information* in reaching their conclusions. The Panel relied almost exclusively on the testimony of those witnesses.

While some hearsay is permissible in these types of hearings, this type of evidence does not rise to the level of hearsay permissible under RCW 34.05.452: “Evidence, including hearsay evidence, is admissible if in the judgment of the presiding officer it is the kind of evidence on which *reasonably prudent persons* are accustomed to rely in the conduct of their affairs.” (emphasis added); *see also Nisqually Delta Ass'n v. DuPont*, 103 Wn.2d 720, 734 (1985) (hearsay evidence is admissible in administrative hearings where it is the “best evidence reasonably obtainable.”).

Here, the Panel itself found that the evidence of Dr. Neravetla’s behavior was *not* reliable, but then relied on assessments premised on that very same information. In essence, the entire case against Dr. Neravetla is premised on Dr. Keith Dipboye’s testimony and information provided to others, including WPHP and Pine Grove. Dr. Dipboye’s flawed

information served as the foundation for opinions of all other Department witnesses, who relied on that hearsay in forming their own opinions. The witnesses for the Department – Dr. Anderson, Dr. Mulvihill, Dr. Meredith, and Jason Green – all testified that their final opinions were based on the faulty foundation of “collateral information,” which was derived primarily from Dr. Dipboye – who was not a primary source. This information was not verified by any of these experts, nor was it presented in any form – other than through hearsay presented by Dr. Dipboye – at the hearing.

However, Dr. Dipboye could himself be accused of disruptive physician behavior, due to his use of profane and disrespectful language, demeaning behavior, negative comments about another physician’s care, criticism of hospital staff in front of patients and others, and more. *See* AR 1108; AR 1990. As such, his testimony and his credibility cannot withstand scrutiny, as are all expert opinions based on the same.

There was not an attempt, either during the assessments or at the hearing, to verify the accuracy of that information. Notably, no witness had worked directly with Dr. Neravetla, such that they could relate first-hand accounts of his “behavior.” The packets of collateral information provided to WPHP and Pine Grove were not similarly provided to the Panel and were not exhibits in this matter.

Moreover, Dr. Neravetla's attorneys were severely restricted in their ability to probe and/or rebut the hearsay. For example, after hours of hearsay testimony from Dr. Dipboye, Dr. Neravetla's counsel attempted to probe that testimony, only to be told that "we're not here to relitigate all of these hearsay reports of various behaviors.... we're not going to be getting too far into this area." AR 2051, ll 7-13; AR 1926-28 (example of hearsay testimony); *see also* AR 2056-59, ll 2-16.

This approach to evidence flies in the face of the protections afforded by the Court in *Nguyen* because of the Court's concerns about the implications for charged physicians. *Nguyen*, 144 Wn.2d at 521. Dr. Neravetla's exemplary career was indeed derailed by this case – the bedrock of which was flawed secondhand information, at best.

G. The Panel's Decision is Arbitrary and Capricious in that It Disregarded the Testimony of All of Plaintiff's Experts.

MQAC's decision in this case is arbitrary and capricious because it disregards the overwhelming evidence that Dr. Neravetla is fit to practice medicine. In doing so, the Panel completely discounted and disregarded the testimony of Dr. Neravetla's experts. It did so because, it alleged, that the experts were solely concerned with ruling out a mental "disorder." AR 1608, ¶1.9(c). However, any review of the record reveals that Dr. Neravetla's experts testified that Dr. Neravetla was fit to practice

medicine. *See* AR 2609-2614; AR 2633; AR 2655-66. They also testified at length regarding what had wrongfully become the central issues in the case – namely the nature of “disruptive behavior,” the definition of a “mental condition” versus disorder, and the basis for the State’s witnesses. AR 2364; AR 2661. The Panel simply ignored this testimony.

Further, the Commission misconstrued Dr. Spencer Eth’s testimony by stating that “[e]ven the Respondent’s expert, Dr. Eth, agreed that the diagnosis of occupational condition was accurate for the Respondent.” AR 1607, n. 4.

Clearly, Dr. Eth in his testimony is describing a common situational stress situation, such as getting fired, reaching one’s credit card limits, getting bad grades in school, etc., and is using the term “mental condition” to characterize a stressful situation that does not rise to the level of a severe, pervasive disease or a disorder. Indeed, the fact that the Panel focused on a specific turn of phrase related to the word “condition” is indicative of the “gotcha” nature of this case.

That the MQAC Panel would choose to ignore or distort the testimony of the expert demonstrates the unbalanced approach taken by the MQAC Panel to the evidence presented by Dr. Neravetla. AR 2659-60. Dr. Eth testified that Dr. Neravetla has never been diagnosed with a psychiatric or substance use disorder, that he was fit to return to full duty

in a postgraduate medical training program. AR 2655-56. Dr. Eth also stated under oath that:

given the absence of a diagnosed medical disorder, the Pine Grove evaluation failed to provide any reasonable basis for its recommendation that Neravetla ought not to attempt to assume responsibilities as a resident physician until he participates in an intensive residential-level treatment program. That recommendation is without merit and should be disregarded.

AR 2655. Such blatant misinterpretation of the evidence in this case calls into question the neutrality of the tribunal and whether Dr. Neravetla was truly given an opportunity to be heard.

H. The MQAC's Order Violates Due Process Because It is Impossible for Dr. Neravetla to Comply with MQAC's Order.

The Department in past filings has attempted to minimize the impact of the ruling on Dr. Neravetla. However, because this is reported to the national database, it effectively prevents his employment as a physician anywhere. Moreover, it is impossible to comply with MQAC's order. In essence, the order's sanctions are conditioned upon (1) Dr. Neravetla getting another residency position, and (2) getting that position in Washington. Unless and until those two preconditions are met, there is

nothing that Dr. Neravetla can do to satisfy the order. However, he has no intention of returning to Washington and cannot obtain a job as a doctor *because of* the existence of the order. Thus, the order will remain in place in perpetuity, ending Dr. Neravetla's career.

As the court in *Nguyen* indicated, a doctor's interest in a professional license is profound. *Nguyen*, 144 Wn.2d at 527. It clearly represents a property interest to which due process protections apply. "Moreover this court has recognized a doctor has a liberty interest in preserving his professional reputation that is entitled to protection under the Fourteenth Amendment." *Id.* (citing *Ritter*, 96 Wn.2d 510-11). "The loss of a professional license is more than a monetary loss; it is a loss of a person's livelihood and loss of a reputation." *Id.*

The *Nguyen* court identified and examined factors articulated by the U.S. Supreme Court: (1) the private interest that will be affected by the official action; (2) the risk of erroneous deprivation of such interest through the procedures used; and (3) the governmental interest in the added fiscal and administrative burden that additional process would entail. *Nguyen*, 144 Wn.2d at 526 (citing *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)) (noting that while *Mathews* court did not consider burden of proof, these factors have some application to that issue as well).

Here, the implications for Dr. Neravetla are enormous. He cannot practice as a result of this order, and his medical career has been effectively halted. Given the passage of time – more than four years since he was a resident – and the fact that he was so early in his medical career, means he may never become a practicing doctor. An order cannot continue in perpetuity with no ability to comply with its terms.

I. The Presiding Officer Violated the Appearance of Fairness Doctrine By Allowing a Former Employee of the Involved Hospital to Remain on the Panel.

A basic requirement of due process is a “fair trial in a fair tribunal.” *Withrow v. Larkin*, 421 U.S. 35, 46 (1975) (quoting *In re Murchison*, 349 U.S. 133, 136 (1955)). A biased decisionmaker violates that 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 (1998). “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. 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 v. Dep't of Health, Dental Quality Assurance Comm'n*, 148 Wn.App. 836, 843(2009). Here, the record does not support a conclusion that all parties obtained a fair, impartial, and neutral hearing.

At the outset of the hearing with the Panel, the Presiding Officer improperly refused to disqualify one of the MQAC members, Thomas Green, M.D., a former physician at VMMC, who admitted to knowing at least one witness, Dr. Owens, from the four-member MQAC Panel hearing the case. AR 1851; AR 1882-88. Dr. Green stated that their “paths had crossed in the operating room.” AR 1887, ll 17-21.

The Presiding Officer allowed Dr. Green to decide for himself whether he could be an unbiased decisionmaker, in one question asking Dr. Green whether he felt he could be impartial. AR 1888, ll 1-7. Given his past relationship with the involved hospital, and the fact that he had worked directly with at least one of the witnesses. Dr. Green should have been excused from the Panel.

J. The Presiding Officer Committed Multiple Prejudicial Errors.

In many other ways, the Presiding Officer made decisions that were legal error, not based on substantial evidence, and/or arbitrary and

capricious. For example, in March of 2014, Dr. Neravetla filed a Motion for Summary Judgment, based upon unrefuted, sworn, expert reports to MQAC to the effect that Dr. Neravetla has never been diagnosed with any mental or physical condition and that he was fit for duty. AR 692-1083. That motion was improperly denied by the Presiding Officer despite the overwhelming evidence that Dr. Neravetla was fit to practice medicine. *See* AR 1026-36; AR 1040-50; AR 1054-76; AR 1371; AR 1533-38.

In another instance, the Presiding Officer refused to allow Dr. Neravetla's counsel to submit his experts' reports to the panel. On January 31, 2014, counsel for Dr. Neravetla filed three expert reports in the case, all stating that Dr. Neravetla does not have a mental health condition and is fit to practice medicine. These reports were later offered as exhibits, however, the Presiding Officer would only allow them in if counsel for Dr. Neravetla would agree to forego direct examination of his witnesses. AR 2601-2605. Such a ruling is very prejudicial, unorthodox, and irregular.

The Presiding Officer also excluded evidence that was probative, such as testimony of former VMMC supervisors and colleagues of Dr. Neravetla, namely chief resident John Roberts— even as a rebuttal witness. AR 2363-2366, ll 12-12. In the same vein, Dr. Neravetla was also prohibited from introducing into evidence various documents, all of which had been made available to opposing counsel well in advance of the

hearing date. The hearing record is replete with examples of the Presiding Officer's exclusionary rulings. *See, e.g.*, AR 2235-2236, ll 22-2; AR 2279-2280, ll 14-1; AR 2363-2366, ll 12-9.

In contrast, the Presiding Officer also allowed Department attorneys to utilize documents handed to them by VMMC's counsel that had never been disclosed to Dr. Neravetla's counsel. AR 2048-50.

All of these decisions, both individually and cumulatively, had the effect of prejudicing Dr. Neravetla.

VI. Conclusion

For the foregoing reasons, Dr. Neravetla respectfully requests that this Court overturn the Panel's decision and rescind the sanctions imposed on Dr. Neravetla.

Dated this 25th day of April, 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.

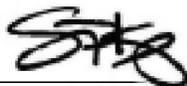
2. I caused to be served upon counsel of record at the address and in the manner described below, on April 25, 2016, the following document: Appellant's Opening Brief.

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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 25th day of April, 2016.



Shawna L. Parks