BEFORE THE
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
STATE OF MISSOURI

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	Case No. 01-0064HA
ABDUL MOHEET, M.D.,	)	
Respondent.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCIPLINARY ORDER

The Administrative Hearing Commission is an agency of the State of Missouri created and established pursuant to § 621.015, RSMo 2000, for the purpose of conducting hearings and making findings of fact and conclusions of law in cases in which disciplinary action may be taken against a licensee or certificate holder by certain agencies, including the Missouri State Board of Registration for the Healing Arts.

1. On June 20, 2002, the Administrative Hearing Commission of the State of Missouri issued its Findings of Fact and Conclusions of Law in the case of *State Board of Registration for the Healing Arts v. Abdul Moheet, M.D.*, Case No. 01-0064HA. In its Findings of Fact and Conclusions of Law, the Administrative Hearing Commission found that Respondent's license to practice the Healing Arts is subject to disciplinary action by this Board for violation of § 334.100.2(5), RSMo 2000.

2. This Board has received the record of the proceedings before the

Administrative Hearing Commission and the Findings of Fact and Conclusions of Law. The Findings of Fact and Conclusions of Law issued by the Administrative Hearing Commission in Case No. 01-0064HA is incorporated herein by reference as if fully set forth in this document.

3. This Board set this matter for disciplinary hearing and served notice of the disciplinary hearing upon Respondent by hand delivery in a proper and timely fashion.

4. Pursuant to notice and § 621.110, RSMo 2000 and § 334.100.4, RSMo 2000, this Board held a hearing on October 18, 2002, for the purpose of determining the appropriate disciplinary action against Respondent's license. Respondent was present for the hearing and was represented by William L. Davis, Attorney at Law. The Board was represented by Assistant Attorney General Daryl Hylton. Assistant Attorney General William Vanderpool served as the Board's legal advisor.

5. Each member of this Board who participated in this decision certified on the record that he or she read the Administrative Hearing Commission's Findings of Fact and Conclusions of Law. All of these members of the Board were present throughout the hearing and participated in the Board's deliberations, vote and order.

6. Abdul Moheet, M.D., Respondent, is licensed by the Board, license number R6F95. Respondent's license is current.

CONCLUSIONS OF LAW

1. This Board has jurisdiction over this proceeding pursuant to § 621.110, RSMo 2000.

2. Respondent's license is subject to disciplinary action by this Board pursuant to § 334.100.2(5), RSMo 2000.

ORDER

THEREFORE, having fully considered all evidence before this Board, and giving full weight to the Findings of Fact and Conclusions of Law of the Administrative Hearing Commission, it is the ORDER of this Board that upon the effective date of this Order the license of Abdul Moheet, M.D., to practice the Healing Arts is hereby PUBLICLY REPRIMANDED.

IT IS SO ORDERED, effective this 19 day of November, 2002.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS

Tina Steinman
Executive Director

Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
vs.	)	No. 01-0064 HA
ABDUL MOHEET, M.D.,	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On January 19, 2001, the State Board of Registration for the Healing Arts (Board) filed a complaint seeking this Commission's determination that the physician license of Abdul Moheet is subject to discipline.

This Commission convened a hearing on the complaint on September 4, 5, and 6, 2001. Assistant Attorneys General Charissa L. Watson and Sreenu Dandamudi represented the Board at the hearing, and Assistant Attorney General Daryl R. Hylton filed the briefs in this case. William L. Davis and Patrick I. Chavez, with Moser and Marsalek, P.C., represented Moheet.

The parties elected to file written arguments. The matter became ready for our decision on May 22, 2002, when the last written brief was filed.

Findings of Fact

1. Moheet is licensed by the Board as a physician and surgeon, License No. R6F95. This license was issued in 1986 and is, and was at all relevant times, current and active. Moheet is certified by the Board in internal medicine.

2. In January 1995, J.D. was a 40-year-old male suffering from high blood pressure, alcoholism, and depression. He occasionally smoked and did not always take his blood pressure medication.

3. On January 19, 1995, J.D. was playing in the snow with his children. They played for about 30 minutes, and J.D. suffered a fall.

4. On January 20, 1995, Moheet was working in the emergency room at St. Luke's Episcopal Presbyterian Hospital (St. Luke's). On average, he worked approximately 50 hours per week. Moheet's ability to communicate with his patients was "absolutely perfect."[1] There were no communication complaints made against him by patients.

5. On the afternoon of January 20, 1995, J.D. was driving home from Central Hardware and felt a sudden and severe headache. He drove home, took aspirin, and lied down with a heating pad. This did not provide relief, and he told his son, Jason, to call 911 for an ambulance at 3:50 p.m.

6. The paramedics responded to what they believed was a stroke call.[2] They took a history of hypertension, depression and alcoholism, and a list of his medications. J.D.'s chief complaint was a headache and neck spasms.

7. At 4:00 p.m., Jason called his mother, C.D., at work and informed her that a paramedic wanted to speak to her. Jason told his mother that his father had had a stroke. The

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[1]Tr. at 396.
[2]*Id.* at 136.

paramedic told her that they were taking J.D. to St. Luke's, and she agreed to meet them there. J.D.'s primary care physician was on staff at St. Luke's, and J.D. had been treated there before.

8. The paramedics put a cervical collar on J.D. and secured him to a spinal board.[3] His blood pressure, taken at 3:59 p.m., was 200/120, and taken at 4:20 p.m. was 170/130. At 4:29, they gave J.D. nitroglycerin sublingually to treat his hypertension. Nitroglycerin lowers the blood pressure and is used as a heart medication to relieve chest pain.[4] J.D.'s blood pressure at 4:30 was 170/P.[5]

9. The paramedics delivered J.D. to St. Luke's and remained there for approximately 50 minutes. They gave a verbal report to a nurse.[6] There was no protocol as to where or to whom paramedics delivered their written reports.[7] At some point this written report would be added to the patient's record.

10. St. Luke's emergency area has a reception area and a triage area.[8] Patients registered at the reception desk, then were directed to the triage station to have their vital signs and initial complaint taken. Then they would be directed to an examining room. When the patient arrived by ambulance, the nurses would be waiting and would perform triage as soon as he or she arrived.

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[3]They took this action as a precaution because J.D. was complaining of neck pain. (Tr. at 147.) The paramedic testified: "And I don't have an X-ray machine in my ambulance. So when somebody complains of neck pain, we put them on a board." *Id.* at 148.

[4]Tr. at 214.

[5]"P" stands for palpitation. Instead of using a stethoscope, the paramedic feels the radial artery. It is possible to get the systolic pressure, but not the diastolic pressure. This method is often necessary because the paramedic cannot hear to use the stethoscope because of the siren or the condition of the road. (Tr. at 161.)

[6]Tr. at 158. This person was not identified, but it was not Douglas Bouldin or Darlene Brooks.

[7]*Id.* at 380-81, 415.

[8]*Id.* at 375.

11. Triage is the process of determining the seriousness of a patient's condition and the immediacy of his or her need to see the doctor. It may involve prioritizing the degree of danger to patients.[9]

12. On the 3-11 shift, the emergency room was typically staffed with two physicians and five to seven nurses because this was the busiest time.

13. J.D. was seen by Douglas Bouldin, R.N., who was the nurse manager of the emergency department. Bouldin filled in an Emergency Room Record Form (the form) with J.D.'s vital signs. J.D.'s blood pressure was 170/130 at 4:50 p.m.[10] Bouldin also recorded his allergies, medication and private doctor's name, and wrote, "cervical neck pain & HA."[11]

14. Having completed his triage duties, Bouldin passed the form to the nurse assigned to the particular block of rooms, Darlene Brooks.[12]

15. C.D. gave Brooks her husband's history,[13] including his blood pressure, hemochromatosis (high iron content), pneumonia, depression, alcoholism, left arm numbness, and a chronic cough. She also told the nurse that J.D. had not been taking his blood pressure medicine.

16. Brooks kept the form with her or on a clipboard while she was responsible for a patient. If Brooks did not have the form with her and needed to make a note about a patient, she wrote on a strip of tape and taped it to her pant leg, then recorded it on the form.[14] By the time the patient left the hospital, the form had to be placed in his or her hospital record.

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[9]Tr. at 386.
[10]Pet'r Ex. 3.
[11]*Id.* HA means headache.
[12]At the time of the hearing, her name was Darlene Hopkins. (Tr. at 404.)
[13]Tr. at 73.
[14]*Id.* at 445.

17. Brooks examined and questioned J.D. and wrote her findings on the form. J.D. told her that while driving the car, he had a "Charlie horse,"[15] causing a severe headache. The pain was in the posterior area up into his head. He said he had numbness around his left wrist, pain in his left elbow radiating to his left wrist. He could not hold up his head without pain. He could not turn his head.

18. Brooks did not take J.D.'s blood pressure.

19. At this time, J.D. was still wearing a cervical collar and beshaw cushion, and was stabilized with a backboard, which would be consistent with a neck injury. He was groaning and clenching his teeth. Brooks instructed him to take deep breaths.

20. At 5:05, Moheet began examining and taking a history from J.D. He observed that J.D. was lying on a backboard in a cervical collar. J.D. was holding the side rails of the gurney, clenching his teeth and going into spasms.

21. When asked why he was in the emergency room, J.D. responded that he was having neck pain that radiated into the back part of his head. Moheet asked if he had hurt himself, and he said that he was sledding in the snow with his son and had fallen.[16] He said he was having numbness in the left arm and particularly around the thumb area and running up towards the elbow.

22. The sixth cervical nerve that extends from the neck serves this part of the left arm. If there are sensory changes in that area, it suggests radiculopathy,[17] that the nerve is being pinched.[18]

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[15]Brooks testified that because these words were in quotation marks, they were J.D.'s words. (Tr. at 420.)
[16]Tr. at 543.
[17]Disease of the nerve roots. DORLAND'S MEDICAL DICTIONARY 1405 (27th ed 1988).
[18]Tr. at 544.

23. Moheet was hampered in taking J.D.'s medical history because the patient was unhappy with the questions and repeatedly requested pain medication.

24. Moheet did a primary survey, checking J.D.'s breathing, pulse, lung sounds, and abdomen. Then Moheet did a neurological check, checking his hand grips and foot movements, and checking his ability to feel sensations by pricking him with a safety pin.

25. Moheet noted that J.D. was complaining of decreased sensation, mostly in the thumb and outer forearm. There was some numbness in the middle finger and on the inner side of the left hand.

26. At 5:20, on Moheet's order, Brooks gave J.D. a shot of Toradol.[19] Toradol is an anti-inflammatory pain reliever. Moheet ordered X rays. He did not order a CAT scan because J.D.'s reflexes were normal.[20]

27. Had J.D. been given a computerized axial tomography (CAT) scan, the intraventricular hemorrhage[21] in J.D.'s brain would have been seen.[22]

28. At 5:35, J.D. was taken to get X rays. When it was determined that J.D. did not have a neck fracture, they took off the collar, beshaw cushion, and backboard. He returned to the emergency room at 6:20.

29. At 6:40, Moheet again examined J.D., who was sitting up on the gurney. Moheet asked J.D. how he was feeling, and he said he was feeling 50% better.[23] Moheet performed a detailed examination, checking skin, head, eyes, ear, nose, throat, neck, lungs, heart, abdomen, and neurological responses.

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[19]Tr. at 423.

[20]*Id.* at 560.

[21]A hemorrhage is "the escape of blood from the vessels; bleeding." DORLAND'S MEDICAL DICTIONARY 750 (27th ed. 1988). The ventricles of the brain are "cavities within the brain which are filled with cerebrospinal fluid[.]" *Id.* at 1828.

[22]Boland Depo. Tr. at 36.

[23]Tr. at 549-50.

30. Moheet did not know J.D.'s blood pressure when he treated him, and did not review the ambulance records or nursing records. Moheet expected his nurse to inform him of any abnormalities in the patient's vital signs.[24] J.D. did not inform Moheet that he had high blood pressure and that he had stopped taking his medication.[25] J.D. did not present the typical symptoms of a stroke.[26]

31. Moheet told J.D. of his diagnosis of a C-6 radiculopathy (sixth pinched nerve) on the left side. He told J.D. that the X ray was negative and that he was being discharged with Robaxin (a muscle relaxant) and anaprox (an anti-inflammatory pain killer).[27]

32. C.D. asked Moheet if these medications would cause a problem with his blood pressure or cause depression. Moheet said that they would not, but that they should not be combined with alcohol. Moheet did not consider the mention of blood pressure to be a reason to reexamine J.D. because blood pressure maintenance is handled by the primary care physician and most cases do not become emergency room situations.[28]

33. At 7:00, J.D. was given a soft collar for his neck, and he was released. Moheet told him to see his private physician the next week and to return to the emergency room if anything changed. At home that evening, J.D. did not eat much and seemed exhausted.

34. Moheet later charted his findings for J.D. based on his notes.

35. A doctor's conduct would fall below the standard of care for treating a patient in the emergency room without knowing his or her blood pressure because he did not obtain an adequate history or seek out this information.[29]

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[24] Tr. at 571.
[25] *Id.* at 573.
[26] *Id.* at 580.
[27] *Id.* at 569-70.
[28] *Id.* at 575.
[29] *Id.* at 223.

36. A doctor's conduct would not fall below the standard of care for discharging a patient from the emergency room with a blood pressure of 170/130.[30]

37. A doctor's conduct would not fall below the standard of care for failing to order a CAT scan for a patient who complained of an elevated blood pressure with neck and head pain because there are many possible reasons for these symptoms.[31]

38. A sudden onset of pain is an indicator that a CAT scan should be performed.

39. The cause of neck pain is most commonly related to cervical disc problems, arthritis, or bone spurs.[32]

40. At approximately 6:30 a.m. on January 21, 1995, C.D. found her husband on the bedroom floor.[33] He was making groaning noises and loud breathing sounds, and she was unable to wake him. C.D. called St. Luke's and then 911.

41. The paramedics arrived and had difficulty getting J.D. downstairs from the bedroom. The ambulance crew took J.D.'s blood pressure four times. At 7:16 his pressure was 220/120; at 7:38 it was 200/128; at 7:45 it was 210/118; and at 7:50 it was 228/108.[34] At 7:38, J.D. received 10 milligrams of Procardia. They drove him to St. Luke's Hospital.

42. At St. Luke's, Dr. Michael F. Boland, a neurosurgeon, examined J.D. and ordered a CAT scan. J.D. was comatose at this time. Boland diagnosed a spontaneous intraventricular hemorrhage that had blocked the pathway of normal spinal fluid absorption. The fluid expanded,

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[30]Tr. at 502, 681-82.
[31]Boland Depo. Tr. at 33; Tr. at 583.
[32]Boland Depo. Tr. at 33.
[33]Tr. at 96.
[34]*Id.* at 164.

and J.D. had developed hydrocephalus.[35] The excess fluid in his brain had built up tremendous pressure and caused him to lapse into a coma.[36]

43. Spinal fluid is produced by tiny organs called choroid plexus. The fluid circulates, and when it reaches the fourth ventricle of the brain it leaves the internal structure of the brain. It travels around the outside of the brain to the top of the skull, where it is reabsorbed into the bloodstream.[37] Spinal fluid supports and cushions the brain, protecting it from the hard bony skull. It provides nutrients for parts of the brain.

44. There are two categories of stroke, an ischemic stroke and a hemorrhagic stroke.[38] Ischemic strokes are caused by occlusion of blood vessels going to the brain. This may happen as a result of a blood clot or because of diabetes. A particular area of the brain is occluded and the brain is damaged, and this causes neurological deficit. The hemorrhagic stroke can be in the substance of the brain or in the subarachnoid[39] or subdural space.[40]

45. J.D. had suffered a hemorrhage (a stroke) in the fourth ventricle; the blood clotted and blocked this flow, leading to an increase of fluid. J.D. suffered the hemorrhage during the afternoon of June 20, 1995, and would have stopped bleeding by the time he arrived at St. Luke's that afternoon.[41] The actual bleeding would have taken place over a matter of minutes, and the amount of blood would be approximately a couple of teaspoons.

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[35]"A condition marked by dilation of the cerebral ventricles, most often occurring secondarily to obstruction of the cerebrospinal fluid . . . . It is typically characterized by enlargement of the head, prominence of the forehead, brain atrophy, mental deterioration and convulsions[.]" DORLAND'S MEDICAL DICTIONARY 783 (27th ed 1988).

[36]Boland Depo. Tr. at 12.

[37]*Id.* at 13.

[38]Tr. at 577.

[39]"Situated or occurring between the arachnoid [delicate membrane in the brain] and the pia mater [one of three membranes covering the brain and spinal cord]." DORLAND'S MEDICAL DICTIONARY 1597, 1293, 119 (10th 3d 1988).

[40]"Situated between the dura mater [outer and most fibrous of the three membranes covering the brain and spinal cord] and the arachnoid." *Id.* at 1598, 514.

[41]Boland Depo. Tr. at 22-23.

46. A hemorrhage can occur due to a ruptured blood vessel or a ruptured aneurysm. Often the reason for the hemorrhage is destroyed in the process of the hemorrhage.[42]

47. The reason for J.D.'s hemorrhage was not determined. The bleeding in the fourth ventricle did not recur.

48. When a person suffers a hemorrhage in this location, he often has a headache and neck pain. There can be complaints of nausea, vomiting, visual disturbances, and a stiff neck. The blood pressure can be elevated or remain normal.[43] Intraventricular hemorrhages of the brain are relatively rare.[44] Most brain hemorrhages are bleedings into the brain substance.

49. A patient who did not have a stiff neck, did not have nausea and vomiting, but complained of a headache associated with neck pain would not be a typical presentation for this type of hemorrhage.[45] The patient can evidence no neurological deficit because there is no destruction of brain tissue.[46] In the normal stroke, there is disruption of the brain substance, and that part of the brain stops working. In the intraventricular hemorrhage, most symptoms will not be evident until the bleeding has been going on for a period of hours.[47]

50. Boland told C.D. that her husband had had a stroke, and that they would need to put a shunt into his brain to drain the spinal fluid and relieve the pressure, or he would die. She authorized the procedure.

51. Boland made a ventriculostomy (a small incision in the scalp), drilled a hole in the skull, and passed a plastic catheter into the spinal fluid space inside J.D.'s brain to allow the

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[42]Boland analogized this to a bomb blowing up in a room. "You never find the bomb, but you can see the destruction that it caused." (Boland Depo. Tr. at 17.)

[43]*Id.* at 32.

[44]Boland testified that he had seen approximately ten in his 16 years of neurosurgical experience. *Id.* at 18.

[45]*Id.* at 18.

[46]*Id.* at 21.

[47]*Id.* at 22, 26.

spinal fluid to escape.[48] He performed this operation in the emergency department because the case was so serious that there was no time to get an operating room.[49]

52. J.D. was in neurointensive care for a week, in a step-down area for a week, and on a rehabilitation floor for a week.

Conclusions of Law

We have jurisdiction to hear the complaint. Section 621.045, RSMo 2000. The Board has the burden of proof. ***Missouri Real Estate Comm'n v. Berger***, 764 S.W.2d 706, 711 (Mo. App., 1989). The agency has the burden to prove its case by a preponderance of the credible evidence. ***Harrington v. Smarr***, 844 S.W.2d 16, 19 (Mo. App., W.D. 1992).

The Board argues that Moheet's license is subject to discipline under section 334.100, RSMo Supp. 1998,[50] which states:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> (5) Any conduct or practiced which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, "**repeated negligence**" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession[.]

[48]Boland Depo. Tr. at 11.
[49]*Id.* at 38.
[50]This subsection is unchanged from the 1994 Mo. Revised Statutes.

Incompetency is either a licensee's general lack of present ability or a lack of a disposition to use his otherwise sufficient present ability, to perform a given duty. ***Missouri Bd. for Architects, Prof'l Eng'rs and Land Surveyors v. Duncan***, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n Nov. 15, 1985), *aff'd,* 744 S.W.2d 524 (Mo. App., E.D. 1988). Gross negligence is "an act or course of conduct which demonstrates a conscious indifference to a professional duty" and that indifference constitutes "a gross deviation from the standard of care which a reasonable person would exercise in the situation." *Id.* at 533 and n.6. We may infer the requisite mental state from the conduct of the licensee "in light of all surrounding circumstances." *Id.* at 533. The standard of care must usually be established by expert testimony. ***Dine v. Williams***, 830 S.W.2d 453, 456 (Mo. App., W.D. 1992).

The Board alleges that Moheet:

a. failed to know or obtain J.D.'s blood pressure;

b. discharged him from the emergency room with a blood pressure of 170/130;

c. failed to obtain an adequate patient history from J.D., the nurse, or the paramedics;

d. reached an incorrect diagnosis because he failed to inquire further into the severity of J.D.'s headache;

e. failed to order a CAT scan;

and that this conduct was negligence, incompetence, gross negligence, and conduct that might have been harmful or dangerous to the physical health of a patient. The Board argues that the course of conduct in Moheet's treatment of J.D. constitutes repeated negligence and incompetence.

I. Sufficiency of Pleading

Moheet argues that the Board's complaint only charges him with gross negligence and incompetence for failing to know J.D.'s blood pressure. Moheet objects to the Board's attempts

to discipline his license for failing to obtain an adequate patient history, failing to note the severity of J.D.'s headache, and failing to order certain tests such as a CAT scan. The Board argues that it did make these allegations in its complaint.

Moheet also argues that the Board is attempting to add new statutory grounds for discipline by arguing that his conduct constitutes repeated negligence and was harmful or dangerous to the patient, when the Board only listed gross negligence and incompetency in its complaint.

A complaint against a professional license must set forth acts that are alleged to be cause for discipline and provisions of law supporting these allegations. The court in ***Duncan***, 744 S.W.2d at 539, set forth the standards required for this pleading:

> The specificity of charges could be at essentially three levels. The most general is simply a statement that the accused has violated one or more of the statutory grounds for discipline without further elaboration, i.e., he has been grossly negligent. Such an allegation is insufficient to allow preparation of a viable defense. The second level involves a greater specificity in setting forth the course of conduct deemed to establish the statutory ground for discipline. The third level involves a degree of specificity setting forth each specific individual act or omission comprising the course of conduct. Due process requires no more than compliance with the second level.

(Citation omitted.) The court stated that the purpose of the complaint "is to inform the accused of the nature of the charges so that he can adequately prepare his defense." *Id.* at 538-39. Our Regulation 1 CSR 15-2.350(2)(A) states that the agency's complaint must set forth:

> 2. Any act the licensee has committed that is cause for discipline, with sufficient specificity to enable the licensee to defend against the charge at hearing; and
>
> 3. Any provisions of law that render these acts cause for discipline.

The Board's complaint states:

> 13. While J.D. was in the emergency room the day before the admission, Licensee knew or should have known that J.D.'s blood pressure was very high.
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> 14. Failure to ascertain a patient's vital signs, including blood pressure, in the practice of emergency medicine is below the standard of care.
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> 15. Licensee's failure to assess J.D.'s blood pressure in the emergency room constitutes gross negligence.
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> 16. Because of Licensee's failure to assess J.D.'s blood pressure in the emergency room, J.D. was deprived of timely diagnosis and treatment of the bleed, reducing the likelihood of a favorable clinical outcome.
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> 17. While J.D. was in the emergency room the day before the admission, Licensee failed to do a complete physical examination of the patient.
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> 18. While J.D. was in the emergency room the day before the admission, Licensee failed to obtain appropriate laboratory tests.
>
> 19. Licensee's failure to adequately assess, diagnose and treat J.D. when he presented in the emergency room was below the standard of care for an emergency department physician.
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> 20. Licensee's conduct, as set forth herein, constitutes incompetency and gross negligence in the practice of medicine.

The Board's complaint then cites section 334.100.2(5), RSMo Supp. 1998, which lists, in addition to incompetency and gross negligence, that discipline is authorized for repeated negligence and conduct harmful or dangerous to the patient or to the public.

We find that the Board's complaint is sufficient to meet the standards set forth in ***Duncan*** with regard to the factual allegations. The Board's complaint sets forth the diagnosis – which includes failing to ask about the severity of the headache, failing to perform a physical examination, and failing to order appropriate laboratory tests.

The Board also gave Moheet notice that negligence was going to be an issue by stating that his conduct "was below the standard of care for an emergency department physician." We find it more troublesome that the Board is relying on the general reference in 334.100.2(5) to provide notice of discipline for conduct harmful or dangerous to the patient, particularly when the Board set forth the allegations of incompetency and gross negligence with such specificity. However, we find that the recitation of the statute, in combination with the reference in ¶ 16 stating that J.D. "was deprived of timely diagnosis and treatment of the bleed, reducing the likelihood of a favorable outcome," provided Moheet with sufficient notice that he might be subject to discipline for conduct that was harmful to a patient.

We overrule Moheet's objections to the sufficiency of the pleadings.

II. Gross Negligence

Moheet argues that the Board presented no evidence and has abandoned its claim that his conduct constitutes gross negligence. We disagree. The Board's expert, Dr. David Tarlow, used the words "gross negligence" in describing Moheet's failure to know J.D.'s blood pressure. He provided ample testimony, giving his opinion on this conduct. He stated: "vital signs are vital. That's why they call them vital signs. And any physician who doesn't know the exact numbers has a conscious indifference to their professional duty."[51]

Whether or not the Board argued that particular conduct constituted gross negligence in its brief, it did not specifically abandon the allegation made in the complaint. Therefore, we could find cause for discipline on that basis.

[51]Tr. at 246.

III. Cause for Discipline

The Board alleges that Moheet's license is subject to discipline under section 334.100.2(5) for gross negligence, incompetence, repeated negligence, and conduct that is or might be harmful or dangerous to the mental or physical health of a patient or the public.

A. Failure to Know or Obtain Blood Pressure

The Board alleges that Moheet's failure to know or obtain J.D.'s blood pressure was negligence, incompetence, gross negligence, and conduct that might have been harmful or dangerous to the physical health of a patient.

Tarlow testified that it was below the standard of care for a doctor to assess, treat and discharge a patient without knowing his blood pressure. He listed many examples of cases in which the blood pressure figure is the triggering factor in making a correct diagnosis.[52]

Moheet argues that he had a "protocol" under which he expected the nurse to inform him of any abnormality in the vital signs. He states that it was a matter of trust.[53] He also notes that neither J.D. nor his wife mentioned the high blood pressure until J.D. was feeling better and was receiving discharge instructions. However, this does not relieve Moheet of his own responsibility in assessing and treating this patient.

Moheet's expert, Dr. Christopher Brooks, testified that Moheet's conduct did not fall below the standard of care because Moheet had a relationship with his nurses to tell him if there were any abnormalities in the vital signs. However, he was unwilling to state that he would have acted as Moheet did in a similar situation:[54]

> Q: And do you typically when you're treating patients, do you typically want to find out what the vital signs of the patient are?
>
> A: Yes, I do.

[52] Tr. at 243-246.
[53] *Id.* at 586.
[54] *Id.* at 480.

> Q: If those vital signs are not provided to you in terms of documentation or not readily available to you within some documents that may be in the emergency department, would you take them yourself?
>
> A: Not usually. I would actively seek out them [sic] and if they're not available have a nurse or one of the medical students or residents working with me, make sure that the vital signs get taken.

Moheet's own witness stressed the importance of the blood pressure numbers. With the evidence before us confirming how important the blood pressure figure is in determining a correct diagnosis, appropriate treatment, and decision to discharge, we find that Moheet's assessment, treatment, and discharge of J.D. when he did not know the patient's blood pressure was gross negligence and conduct that might have been dangerous or harmful to the physical health of a patient. We do not find that it was incompetence. One instance of negligence does not constitute incompetence. ***Bever v. State Bd. of Regis'n for the Healing Arts***, 2001 WL 68307 at 17 (Jan. 30, 2001), *reh'g denied*, March 27, 2001.[55]

B. Discharge of Patient With High Blood Pressure

The Board alleges and Tarlow testified that releasing J.D. with a blood pressure of 170/130 was negligence, incompetence, gross negligence, and conduct that could be harmful to a patient. Boland testified that he would not have discharged J.D. with that blood pressure.[56]

There was a great deal of testimony concerning what Moheet should have done had he known J.D.'s blood pressure. This is valuable testimony to prove the importance of knowing the vital sign. However, the Board is also attempting to argue that Moheet's license is subject to discipline for failing to take actions he should have taken had he known. He did not know J.D.'s blood pressure when he diagnosed and treated J.D. He has admitted that, and we have found

[55]This is not a final, published decision.
[56]Boland Depo. Tr. at 54-55.

cause for discipline on that charge. We will not now assume that he knew the fact and find cause for discipline for what he should have done.

In any event, Brooks testified that he would not even have given additional medication for the elevated blood pressure. He stated that he would have talked with the patient about the blood pressure and suggested that the patient see his doctor soon, take the pressure again, and possibly adjust the blood pressure medication.[57] Moheet testified that hypertension, in and of itself, is not an emergency room issue unless it is an extreme condition, and that most patients with high blood pressure are managed by the primary care physician.[58]

This conduct does not fall below the standard of care for an emergency room doctor and is not gross negligence, incompetence or conduct that would be likely to cause harm to a patient. We find no cause for discipline for discharging J.D. from the emergency room with an elevated blood pressure.

C. Failure to Obtain Adequate Patient History

The Board argues that Moheet failed to obtain an adequate patient history from J.D. and from the paramedics, and that this was negligence, incompetence, gross negligence, and conduct that was harmful or dangerous to a patient.

Moheet did not review the ambulance or nursing records that would have informed him of J.D.'s blood pressure, his history of hypertension and alcoholism, and the fact that the ambulance crew had believed that they were responding to a stroke call and had already administered nitroglycerin. Although Moheet did not expect to have to go searching for this information, it was available to him. We believe him when he testifies that he had a relationship with his nurses in which they were expected to tell him if there were any abnormalities in the

[57]Tr. at 502.
[58]*Id.* at 575.

vital signs of a patient. However, this is not simply a case of vicarious liability for someone else's actions. Moheet is not being held responsible for the nurse's actions in failing to inform him, but for his own actions in failing to ascertain and assess this information.

Moheet argues that he was relying on J.D. to provide his medical history, but admits that J.D. was not a cooperative patient and repeatedly asked for pain medication instead of answering Moheet's questions about his history. (Finding 23.) While Moheet's expert, Dr. Ben M. Gasirowski, testified that it is rare for emergency room doctors to talk to paramedics,[59] under these circumstances Moheet should have contacted someone – the nurse, the paramedics, or the person to whom the paramedics gave the oral report to get adequate information.

This failure to ascertain and assess information about a patient in order to adequately prepare a patient history constitutes conduct that falls below the standard of care for an emergency room doctor. It constitutes gross negligence and conduct that would be likely to cause harm to a patient. It was not incompetence. The conduct is cause to discipline Moheet's license.

D. Failure to Inquire into the Severity of J.D.'s Headache

The Board argues that Moheet reached an incorrect diagnosis because he failed to inquire further into the severity of J.D.'s headache and that this was negligence, incompetence, gross negligence, and conduct that was harmful or dangerous to a patient. Testimony established that Moheet incorrectly diagnosed J.D.'s condition. He diagnosed C-6 radiculopathy (a pinched nerve). (Finding 31.) J.D. was actually suffering from a spontaneous intraventricular hemorrhage. (Finding 42.)

[59]Tr. at 726.

Tarlow testified that Moheet should have asked more questions about J.D.'s headache. He postulates that if Moheet had done so, J.D. would have revealed that the onset of the headache had been severe and sudden.[60] J.D. might also have mentioned his blood pressure in context with the headache. He testified as follows:[61]

> Q: Doctor, I want to stop you for just a second and make reference to a headache and talk about it being the worst headache of the patient's life. Is that a question that you want to ask someone who presents in the emergency room with a headache?
>
> A: Absolutely. That's one of the most important questions you ask, is it the worst headache of your life and is this the first time you've had headaches. It's very unusual for someone who's fifty years old to suddenly develop headaches. It could be a brain tumor. It could be many things. People generally do not start off with headaches in mid life. They typically have long histories often. So the first headache of your life, even if it's a migraine, all migraine headache people eventually get a CAT scan. But this is an emergency department. So is this the worst headache of your life.

The Board argues that even Dr. Brooks testified that the question should be asked in order to reach a correct diagnosis. Brooks testified that he usually asked a headache patient if it is the worst headache of his or her life.[62] However, as Moheet argues, this question was dependent on the pain being characterized as a severe headache. J.D. informed Moheet that he was suffering from and exhibited symptoms of severe neck pain.

Brooks testified:[63]

> [J.D.] presented with neck pain, with arm symptoms and this headache. If I had been there seeing him, I would have focused my evaluation, my physical exam and my history on geez, what did you do to your neck, let's look at your arms, see what's going on there. My initial impression would have been that this

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[60]Moheet knew of the sudden onset of the pain. He charted that J.D. had "suddenly developed spasms in the neck causing severe pain . . . ." (Tr. at 563; Pet'r Ex. 3) (emphasis added).

[61]Tr. at 275-76.

[62]*Id.* at 469.

[63]*Id.* at 484.

> headache was pain radiating from his neck up to the posterior part of his head. And it's very likely that I wouldn't have asked him if it was the worst headache of his life.

Gasirowski testified that if a severe headache is the only symptom, it would be appropriate to ask the question, but it was not below the standard of care to fail to ask when a patient exhibits other symptoms consistent with another diagnosis.[64] He stated:[65]

> If the patient is complaining of neck spasms with referred pain and all the other signs and symptoms that we've gone over for the last couple hours, they're all consistent with cervical pathology. So in that case you would not ask that question.

There is ample evidence that J.D. was not presenting as a typical stroke patient. He had suffered from a relatively rare intraventricular hemorrhage. (Finding 48.) Moheet was given a logical scenario – playing in the snow and falling – to explain symptoms that J.D. was complaining about and experiencing.

Gasirowski listed specific symptoms that J.D. had exhibited and facts that he gave Moheet, including trauma while driving, pain that got better and worse, and numbness around the left wrist that had been present for seven to ten days.[66] He testified that it would not be unusual for a patient to experience more pain 24 hours after a traumatic event, so it was reasonable for Moheet to consider the incident of falling while playing in the snow. He testified that all the information from the physical evaluation and history was consistent with a diagnosis of cervical muscle spasm.[67]

Although Moheet's diagnosis was incorrect, we find that his failure to ask if J.D. was experiencing the worst headache of his life does not fall below the standard of care for an

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[64]Tr. at 728.
[65]*Id.* at 733.
[66]*Id.* at 647-650. The doctor notes: "[J.D.] wasn't having a stroke for seven to ten days." *Id.* at 649.
[67]*Id.* at 729.

emergency room doctor and is not gross negligence, incompetence, or conduct that would be likely to cause harm to a patient.

E. Failure to Order CAT Scan

The Board argues that Moheet reached an incorrect diagnosis because he failed to order a CAT scan and that this was negligence, incompetence, gross negligence, and conduct that was harmful or dangerous to a patient.

Tarlow testified that a CAT scan was mandated for someone in J.D.'s condition.[68] It is true that a CAT scan would have shown the hemorrhage, but this hindsight cannot be dispositive as to whether Moheet, presented with J.D.'s symptoms, should have ordered the test.

Brooks testified that even if Moheet had known J.D.'s blood pressure, ordering a CAT scan would not have been required to meet the standard of care. He stated that in this situation, he would have rechecked the blood pressure, made certain that J.D. was taking his blood pressure medication, and suggested that he obtain follow-up with his private physician. Brooks' testimony was as follows:[69]

> Q: So issues involving acute problems or current problems with blood pressure are less in some way than the long-term, the chronic consequences?
>
> A: I don't want to say less. When we get in a situation where the blood pressure needs to be lowered acutely, it's usually what we call a hypertensive emergency. The blood pressure is way, way high and there are problems directly related to that. . . . For the most part, though, when we see patients in the emergency department with high blood pressure, I think it's a bad idea to try to lower their blood pressure because there are no benefits but there are risks associated with it.

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[68] Tr. at 240.
[69] *Id.* at 473-74.

Moheet testified that the patient was not complaining of the worst headache of his life, or even of a headache. J.D. was complaining of neck pain that radiated into his head.[70] Boland testified that, given the set of facts presented to Moheet, it was a reasonable assumption that the patient was suffering from cervical pathology.[71] Boland testified that a CAT scan would not have been a necessary test for a patient who had neck pain even with an elevated blood pressure. He stated:[72]

> As alluded to earlier, there are many causes for those types of things. In somebody neurologically normal; hypertension, blood pressure is very common among the American public. And the vast majority of the reasons for elevated blood pressure have nothing to do with the central nervous system. As we alluded to earlier, the causes of neck pain most commonly is related to cervical disc problems, arthritis, bone spurs, those kinds of things; and very rarely is it due to hemorrhages. So that the fact that he complained of neck pain, some intermittent headache with an elevated blood pressure, does not necessarily prompt one to get a CAT scan of the head.

Gasirowski testified that doctors do not order CAT scans on everyone who is treated in the emergency room because there are risks and costs associated with the test.[73]

We find that this conduct does not fall below the standard of care for an emergency room doctor and is not gross negligence, incompetence, or conduct that would be likely to cause harm to a patient. We do not find cause to discipline Moheet's license for failing to order the CAT scan.

F. Repeated Negligence/Incompetence

The Board argues that the course of conduct in Moheet's treatment of J.D. constitutes repeated negligence and incompetence. In order to find repeated negligence, the conduct falling below the standard of care must occur on more than one occasion. The facts and allegations in

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[70]Tr. at 581.
[71]Boland Depo. Tr. at 58.
[72]*Id.* at 33-34.
[73]Tr. at 746.

this case are so intertwined that it is difficult to separate them into separate occasions. The Board cites cases in which this Commission has found cause for discipline for repeated negligence for two acts involved in performing the same procedure, and for acts on different days but involving treatment for the same condition. We have found that Moheet was grossly negligent because he assessed, treated and discharged J.D. without knowing his blood pressure, and found that Moheet was grossly negligent because he did not actively seek out the information about the blood pressure and medical history, which might have led him to the correct diagnosis. These are not two separate occasions. In essence, these are two allegations arising from the same event - Moheet's knowledge of his patient's blood pressure and medical history and how it affected his treatment of J.D.

We do not find cause for discipline for repeated negligence. We find that, under the facts of this case, two instances of gross negligence occurring on one occasion does not constitute incompetence.

Summary

We find cause to discipline Moheet's license under section 334.100.2(5) for gross negligence and conduct that might have been harmful or dangerous to the physical health of a patient, in that he diagnosed, treated and discharged J.D. without knowing an important vital sign, his blood pressure, and for failing to obtain an adequate patient history. We do not find cause for discipline for any other conduct listed in the Board's complaint.

SO ORDERED on June 20, 2002.

SHARON M. BUSCH
Commissioner