IN RE: AGGRIEVED PRACTITIONER	*	**NO. 2017-CA-0298**
	*	
		COURT OF APPEAL
	*	
		FOURTH CIRCUIT
	*	
		STATE OF LOUISIANA

* * * * * * *

APPEAL FROM
CIVIL DISTRICT COURT, ORLEANS PARISH
NO. 2015-10769, DIVISION "C"
Honorable Sidney H. Cates, Judge
* * * * * *
Judge Marion F. Edwards, Pro Tempore
* * * * * *

(Court composed of Judge Roland L. Belsome, Judge Joy Cossich Lobrano, Judge Marion F. Edwards, Pro Tempore)

LOBRANO, J., CONCURS IN THE RESULT.

James M. Williams
Conrad Meyer
CHEHARDY, SHERMAN, WILLIAMS, MURRAY, RECILE, STAKELUM & HAYES, L.L.P.
One Galleria Blvd., Suite 1100
Metairie, LA 70001

-AND-

Stewart E. Niles, Jr.
Bryan J. Knight
NILES, BOURQUE & KNIGHT, L.L.C.
909 Poydras Street, Suite 3500
New Orleans, LA 70112

COUNSEL FOR PLAINTIFF/APPELLEE

Ralph H. Wall
Raymond P. Ward
ADAMS AND REESE LLP
701 Poydras Street, Suite 4500
New Orleans, LA 70139

COUNSEL FOR DEFENDANT/APPELLANT

REVERSED; DECISION OF THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS REINSTATED

NOVEMBER 15, 2017

The Louisiana State Board of Medical Examiners (the Board) appeals a judgment of the trial court remanding this matter back to the Board for reconsideration of a decision to revoke a member's license to practice medicine. We reverse and reinstate the decision of the Board.

Plaintiff, Aggrieved Practitioner (AP), a physician licensed to practice medicine in the State of Louisiana, filed a petition in the district court for judicial review and/or appeal of a decision by the Board revoking his license to practice medicine on grounds of incompetence involving AP's performance of Transforminal Lumbar Interbody Fusions, a neurosurgical spine procedure performed by both neurosurgeons and orthopedic surgeons. After a hearing on the matter, the trial court found that the hearing conducted by the Board was "in violation of AP's constitutional due process rights, made upon unlawful procedure, and clearly arbitrary and characterized by an abuse of discretion." However, the trial court did not reverse, vacate or amend the decision of the Board. Instead, the trial court remanded the matter for a new trial "to allow full development of the

record where all relevant, competent evidence…should be considered by the Board and then they can give that evidence whatever weight they think it deserves."

The Board appeals and assigns two errors; that the trial court erred in remanding the matter for the taking of additional evidence, and in concluding that the penalty imposed by the Board is too harsh.

PROCEDURAL HISTORY

This matter began on June 10, 2010 with a letter to AP informing him of an initial investigation by the Board concerning certain complaints received. Shortly thereafter the parties met and agreed that AP would not perform Transforminal Lumbar Interbody Fusion (TLIF) surgery during the investigation. It was also agreed that AP would submit to certain evaluations from the Physician Assessment and Clinical Evaluation program (PACE) and Clinical Competence Solutions (CCS). On September 3, 2010, the Board wrote to AP acknowledging his participation in PACE, but informing AP that there was no indication that he entered into an agreement with CCS or any other comparable entity. The letter also indicated the Board received information suggesting that AP performed recent TLIF surgeries, and informed him of additional complaints questioning his surgical competence.

On September 20, 2010, the parties entered into an interim consent order whereby AP agreed not to perform surgery until the Board issued a decision or an order removing the restriction. The order also mandated that AP participate in a Board approved assessment, training, or clinical course of study.

On March 20, 2012, a formal complaint to the Board was filed, charging AP with 23 counts of medical malpractice involving numerous violations of the

Medical Practice Act embodied in La. R.S. 37:1261 et seq. Specifically, AP was charged with the following violations relating to 23 patients:

1.) Professional or medical incompetency

2.) Unprofessional conduct

3.) Continuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of medical practice in this state

4.) Abandonment of a patient

5.) Knowingly performing any act which, in any way, assists an unlicensed person to practice medicine, or having professional connection with or lending one's name to an illegal practitioner

AP filed an answer, exceptions of vagueness, ambiguity and lack of amicable demand as well as a reconventional demand alleging that the complaints made against him were initiated and generated by a plaintiffs' counsel who represented 12 of the 23 patients identified in the complaint to further his civil suits against AP. AP asserted his rights of due process and equal protection were violated throughout the undue delay of the Board's investigation and for "unreliable, inefficient and indefensible process", and abuse of prosecutorial discretion and misconduct. AP also made allegations against the Board including violation of right to privacy, publically putting AP in a false light, and forcing him to sign an interim consent agreement in order to aggregate newly filed claims with prior claims. AP's assertions of violation of his equal protection rights include fundamentally unfair treatment. AP also makes a claim of breach of contract relating to alleged breaches of an informal agreement between the parties, as well as the interim consent order. He asserts vices of consent to vitiate consent, fraud, misrepresentation, duress and detrimental reliance relating to the interim consent order. Finally, AP argued the Board should be estopped from bringing any

complaints against him that are outside of the scope of the investigation pending at the time of the informal agreement.

On October 14, 2013, AP proposed a consent order which would vacate and supersede the prior interim consent order. Under the new proposed consent order, AP's license would be limited to a non-surgical practice. However, that limitation would be removed upon his acceptance of and strict compliance with certain conditions, including his acceptance into and completion of a Board approved neurosurgery graduate medical education program. That proposal was rejected by the Board.

The Board assembled a panel of four physicians presided over by an independent counsel to conduct the investigation into the allegations against AP. After discovery and several continuances, the Board conducted hearings between February 21, 2015 and June 29, 2015; and, on October 26, 2015, the Board rendered a decision finding that AP failed to satisfy the prevailing and usually accepted standards of medical practice in the State of Louisiana. The decision also found AP "guilty' of violating the Louisiana Medical Practice Act (La. R.S. 37:1285(13)), in that AP failed to create adequate medical records. However, the Board found AP "not guilty" on the charges of abandonment of a patient and of assisting an unlicensed person to practice medicine.

AP filed a motion for rehearing that was denied by the Board. AP filed an appeal of the Board's decision with the district court. Upon consideration of the merits of AP's appeal, the district court rendered an opinion remanding the matter back to the Board for further proceedings, but did not reverse, vacate or alter the Board's ruling. That judgment is now before this Court on appeal from the Board.

FACTS

The allegations of incompetence relate to a minimal surgical spinal fusion procedure known as Transforminal Lumbar Interbody Fusion. According to the expert testimony, in this surgery there are two goals, to decompress the nerve root between two vertebrae, and to ultimately fuse those two segments together. To accomplish this, the surgeon removes disc materials between the vertebrae and places a cage into the disc space with bony materials harvested, along with other donated allografts or bone grafts, in hope of fusing the spinal segment. The purpose is to restore the lost disc space and decompress the nerve to alleviate pain. The cage inserted into the spinal column is designed to allow bone growth.

It is necessary to optimize the environment where the bone could grow between the discs. To do that, a surgeon must remove disc materials to create the empty space to place the bone grafts that are harvested and place a cage in the space to hold the bone graft in place until it fuses.

At the hearing before the Board, the complainant went forward with 11 of the original 23 cases cited in the complaint against AP. In its consideration of the complaint, the Board heard testimony, offered by both parties to the complaint, from various experts in the fields of neurosurgery, spinal surgery, minimally invasive surgery, orthopedic surgery, instrumentation surgery, radiology, interventional neuroradiology, kyphoplastic surgery, neuroradiology-neurosurgery, and residency training. Additionally, the Board considered the medical records of the 11 patients whose treatment forms the basis of the complaint, and heard testimony from some of those patients.

THE ELEVEN PATIENTS

1.) O.B.[1]

O.B. was a 72 year-old man with a history of back pain at the time he saw AP. Because conservative treatment proved ineffective and the pain was getting worse, O.B. consulted AP. Physicians who testified agreed that O.B. had severe spinal stenosis. AP ordered a discogram which showed no pain for all levels from L1-L2 to L4-L5, but severe pain at level L5-S1. AP performed an L5-S1 fusion and an L4-5 and L3-4 decompression. After the surgery, O.B. experienced significant pain, and muscle spasms, a new symptom. AP decided that the pain was due to inflammation rather than any post-surgery problem. AP discharged O.B. and referred him to a pain management physician.

O.B. subsequently saw Dr. Powell Auer, who ordered MRI and CT scans which revealed "diffuse severe degenerative changes everywhere." Dr. Auer testified at the hearing and stated that in this case a "discogram is completely useless" and the decision to do a one level fusion was "absurd". The tests also showed that the cage inserted by AP was misplaced and was the likely cause of O.B.'s pain. Dr. Auer explained that AP failed to remove sufficient disc tissue to allow the vertebrae to fuse. Dr. Auer also found fault with AP's failure to perform the laminectomy to decompress the nerve roots, leaving O.B. with unrelieved severe lumbar stenosis.

All testifying doctors agreed that the cage was misplaced and could be a source of O.B.'s pain, although two doctors who testified for the defense were of the opinion that the surgical procedure did not breach the standard of care.

[1] The patients will be identified by initials only to protect their privacy.

However, these doctors did agree that the attempted laminectomy failed to adequately decompress the nerve roots. It was clear from the testimony that testifying doctors were disturbed by the fact that AP did not adequately investigate the cause of the post-op pain and was not truthful with the patient.

2.) K.I.

K.I. was a 24 year-old woman who sought treatment from AP for back and leg pain. She was able to manage the pain with low level medication and was functioning adequately as a student. AP performed a decompressive factectomy at L5-S1. AP testified that this patient had a "tricky anatomy" and that she did not have the normal amount of disc space. However, AP testified that he tapped the cage into place and verified its proper placement on the C-arm fluoroscopy. The surgery not only made the pain worse, it caused numbness and tingling below the waist, as well as pain in her right foot. After the post-op worsening of pain, AP ordered an MRI and a CT scan, which according to AP's testimony revealed that the cage was properly placed inside of the vertebrae. AP referred K.I. to a pain management physician.

K.I. sought a second opinion from Dr. Anthony Sin. Dr. Sin reviewed the MRI and CT scan and found that the cage was outside the vertebral body itself and could not have migrated there. Dr. Sin also testified that K.I. has hemi-vertebrae, a genetic malformation of her vertebral spine and was never a candidate for the surgery performed by AP because there is no room for the cage used in such surgeries.

Because K.I. was forced to use a wheelchair and was hospitalized for treatment of an infection after the surgery performed by AP, Dr. Sin consulted two other physicians and waited a few months before making a treatment plan for K.I.

Ultimately, Dr. Sin performed surgery on K.I. exploring the area, finding compression of the nerve roots. Dr. Sin found no evidence of a facetectomy or micro-discectomy as recorded by AP in the medical records. Dr. Sin did what he could to decompress the nerve roots to relieve the pain, with some success. After this surgery, K.I.'s pain lessened. Both Dr. Sin and Dr. John Steck, who testified for the defense, agreed that AP failed to comply with the standard of care in his treatment of K.I.

3.) J.C.

J.C. had a history of spinal and leg pain resulting from a fall about 20 years earlier. AP ordered a discogram and found that J.C. had mid-level pain at L4-L5. AP performed a TLIF at that level, but did not schedule any post-surgical evaluations. About two months after the surgery, J.C. returned to AP with complaints of lower back pain in addition to pain in new areas of the spine. AP ordered a second discogram which showed that the pain level at L3-L4, one level above the surgical site, had gone from no pain to severe pain. AP performed a second surgery at the L3-L4 level. AP saw J.C. again about four months after this surgery. The pain continued and AP recommended a spinal cord stimulator. It was not until the final visit, over one year after the first surgery and about eight months after the second, that AP ordered x-rays to check the surgical hardware. The x-rays showed no spinal fusion occurred in either surgical area.

Dr. Milan Moody, who subsequently treated J.C., testified that the tests showed a multi-level pathology with degenerative changes of the facet joints. Dr. Moody testified that the single level fusions performed by AP had a high chance of failure because of the severity of the degenerative disc disease. He explained that a one level fusion would only move the pain up one level leading to "failed back

syndrome." In fact, Dr. Moody testified that this case is being used as a teaching tool to show doctors what not to do.

Dr. Moody performed surgery on J.C. in which he did a revision decompression fusion spanning from L3 to S1. The old cages were removed and replaced with new cages properly placed in these disc spaces, old screws were removed and new screws placed at the L3-L4 and L5-S1 levels. During the surgery, Dr. Moody observed that there was a lack of bone growth caused by the AP's failure to properly prepare the surgical site where the fusion was attempted.

Based on the records and medical tests, Dr. Moody was of the opinion that recommending a single level L4-L5, rather than a multi-level fusion for this patient's degenerative disc disease was a breach of the standard of care. Two doctors who testified on AP's behalf disagreed with that opinion, and believed that the treatment did not breach the standard of care.

4.) B.M.

B.M., a man in his forties, went to AP complaining of low back and right leg pain that was ongoing for the past 10 years and was diagnosed as having degenerative disc disease. Tests showed the degenerative discs at L5-S1 were the worst. AP discussed options with B.M., including a minimally invasive TLIF. B.M. told AP that he was very active, still playing baseball and horseback riding. According to B.M., AP told him there was an 85% chance he would be back to those activities with no problems. AP denied making this promise to this patient.

B.M. opted for the surgery and AP performed a TLIF. When B.M. experienced post-op pain, AP ordered an MRI and a CT scan. AP checked the tests and informed B.M. that everything was fine, but it would take a year to heal.

When the pain did not subside, B.M. consulted Dr. Powell Auer who viewed the MRI and CT scan taken by AP. Dr. Auer testified that, while a two level fusion would be reasonable if the patient had insisted and fully understood the risks, he would not recommend that surgery for this patient. Dr. Auer also testified that the original CT scan showed the cage was in the wrong place and this was pointed out by the radiologist.

Dr. Auer performed surgery on B.M. in which he removed the cages and remaining disc material to make way for new, properly placed cages. Dr. Auer testified that the original surgery would never have worked because there was insufficient disc material removed and cage was misplaced and pressing on the nerve root. Dr. Auer stated that, in essence, the operation was half done. AP simply made a hole, rather than removing the disc, and tried to force the cage into the hole.

Dr. Auer believed that B.M.'s level of function before the surgery was much too high to warrant surgery. In Dr. Auer's opinion, B.M. would not have consented to the surgery if he had been properly informed of the risks and the likely outcome. It was Dr. Auer's opinion that AP's treatment was below the standard of care. Dr. Voorhies, who testified in AP's defense disagreed with Dr. Auer's assessment that AP's treatment of B.M. was below the standard of care.

5.) A.J.

A.J. went to AP with complaints of neck, leg and arm pain. This patient is a woman who is morbidly obese. An MRI showed a large diffuse herniation at C7-T1. AP recommended an anterior cervical disc fusion. However, AP was unable to complete the surgery because the retractor was not long enough. Consequently AP completed the surgery posteriorly, even though he had only discussed and

gotten consent for an anterior surgery. He did, however, get the patient's husband's consent before completing the surgery.

The testimony regarding the surgery indicates that AP's treatment met the acceptable standards. However, there was testimony to show that AP's post-operative medical records on this patient are incomplete.

6.) C.N.

C.N., a teenaged girl, sought treatment with Dr. Steven Cox for pain in her back, and legs. Dr. Cox conducted diagnostic tests and concluded that this patient should be treated with physical therapy rather than invasive treatment. She then consulted AP, who ordered an MRI and a discogram. AP testified that he was reluctant to operate on a 19 year-old girl; however, C.N. told him the conservative treatment was not working and she wanted relief from the pain. AP performed a fusion at L5-S1. Two days later C.N. called AP complaining of lower back pain that radiated into her hip. About two weeks later, AP saw C.N. and reported that all was well and did not document any physical evaluation. AP explained that it is his practice only to document abnormal findings. It also appears from AP's testimony that he did establish a regular schedule for his post-op patients as a general rule. About one month later, C.N. called to report pain and weakness in her back. AP referred her to physical therapy. Three months later, C.N. pain was getting worse. About one year after the surgery, AP ordered an MRI and a CT scan which showed a moderate to large central disc bulge or herniation at L4-L5.

The C.N. made a complaint and the case was referred to a Medical Review Panel. One of the doctors on that panel testified at the hearing. He stated the panel did not find AP had breached the standard of care in this case.

Dr. Nunley, a physician who subsequently treated C.N. disagreed with the medical panel's assessment. Dr. Nunley testified that a single lever fusion was inappropriate for this patient considering the findings at L5-S1. C.N. required revision surgery to remove the spinal-cord stimulator and revise the fusion surgery performed by AP.

7.) W.H.

W.H. presented as an adult male with a history of an L4-L5 and L5-S1 fusion performed 7 years earlier. He had a significant herniated disc at L3-L4. A discogram revealed fissures at levels L3-L4, L4-L5 and L5-S1, although W.H. only reported pain at the L3-L4 level. AP performed fusion surgery at all three levels to repair the fissures. AP performed a second surgery about five months later to correct a problem with the placement of the cage at the L5-S1. According to AP's testimony, the cage at that level had subsided into the vertebral body as a result of the nature of tissue and bone encountered at that level. Dr. Nunley, the subsequent treating physician who saw W.H. about one year later, testified that W.H. had been treated for a lengthy time for infection after the second operation. Dr. Nunley conducted tests which showed the cage at the L5-S1 was actually placed into the vertebral body and did not subside into it. After viewing the CT scans and fluoroscope from the second surgery, Dr. Nunley concluded that AP drove the previous cage through the vertebral body into a position that could cause great harm. Dr. Nunley also believed that the cause of the infection and some of the pain experienced by this patient was due to the misplaced screws at L5-S1. To alleviate these problems, Dr. Nunley surgically removed the screws. Dr. Nunley was of the opinion that the misplacement of the cage, which was clearly shown on post-operation imaging, was a breach of the standard of care.

Dr. Ramos acknowledged that the cage was partially inside the vertebral body, and that the original cage was moved a bit in the second operation. However, Dr. Ramos disagreed that AP breached the standard of care in the treatment of W.H.

8.) K.F.

When K.F. went to AP, he had previously received a prior micro-discectomy at L5-S1. AP ordered a discogram which revealed intense concordant pain at level L3-L4, but no pain at L5-S1. AP performed a TLIF at L3-L4. When the pain did not subside after the surgery and several pain injections, K.F. sought a second opinion from Dr. Nunley. Dr. Nunley reviewed the inter-operative studies and concluded that the cage was only halfway in the disc space. Dr. Nunley performed surgery on this patient and found no fusion at the site of Aps surgery about one year before.

In K.F.'s case, the medical review panel found AP failed to meet the applicable standard of care in the failure to remove sufficient disc material, failure to schedule sufficient follow-up visits considering the neurological deficits, and failure to inform the patient of the misplacement of the cage. Dr. Ramos disagreed with the panel's findings.

9.) S.E.

S.E., a 24 year-old woman, suffered a fracture at the L2 level in a fall. Ten days after the fall, AP performed kyphoplasty on S.E. AP testified that this option would give S.E. immediate relief from the pain, whereas conservative treatment with a back brace would take months. In kyphoplasty, radiopaque cement is injected into the affected vertebra using thoracoscopy to guide the surgeon. In S.E. case, a subsequent MRI showed radiopaque cement leaking into S.E.'s veins from

the site of the injection all the way up to the inferior vena cave. There is expert testimony to indicate that this is not an abnormal occurrence with this procedure. However, the condition must be documented in the patient's record; and further, a thoracoscopy of the chest area to document that there was no cement in that area should be done. AP did neither. There was also expert testimony questioning the adequacy of the consent form.

The Board found that, while the surgery was performed in a manner consistent with the standard of care, the failure to record the extensive extravasation in the notes and the decision to perform this surgery on a 24 year-old without considering conservative treatment was a breach of the standard of care.

10.) P.P.

P.P., an elderly patient with chronic back pain went to AP for treatment. She was diagnosed with a large mass at L2 that was in the epidural space, encasing the nerves and eating away at the bone. AP performed a kyphoplasty on P.P. at the T4 and L2 levels before the patient began radiation for treatment of the tumor. Experts testified that, while this procedure can be appropriate for treating fractures in the spine from malignancies, in this case there was nothing to keep the cement in place because of the absence of bone. Dr. Wojak testified that the danger is that the cement could push the tumor into the canal and potentially cause problems with the nerves, leading to possible loss of bowel and bladder control, or even paralysis. In short, a compression fracture in this patient could not be repaired because there was no bone left to repair. As with S.E. there were issues raised concerning the sufficiency of the consent form.

After the surgery, P.P. complained of leg weakness consistent with cord compression and numbness from the waist down. Post-operative tests showed the

cement did not stay within the vertebral body; however, this fact is not documented in the operative report.

10.) M.S.

M.S. sought treatment after being diagnosed with a large acoustic neuroma to the brain stem. AP considered M.S. a candidate for the Gamma Knife. AP testified that he removed as much of the tumor as possible without affecting the facial nerve. M.S. consulted Dr. Nanda about 4 months after the surgery. Dr. Nanda testified that the tumor was too large to be surgically removed with a Gamma Knife. He was of the opinion that a tumor this size must be de-bulked surgically. He stated that an MRI showed a minimal amount of the tumor was removed by AP and he found no interim or post-op MRI conducted by AP to check the results of the use of the Gamma Knife. After the surgery, M.S. reported new neurological complaints that he had no taste sensation on the left side and no coordination on the right side. Dr. Nanda opined that AP should have ordered an MRI to evaluate these new symptoms.

There was also testimony from experts who were of the opinion that the surgery was not performed in a negligent manner and that AP's post-operative care met the standard of care.

With M.S. as with some of the other patients in this analysis, the Board found AP's post-operative care to be below the standard of care.

After the extensive hearing eliciting all of the above discussed evidence, the Board's findings were that there were several incidents in which AP recommended inappropriate surgery, failed to perform surgery in a technically competent manner, misplaced the cage after inadequate decompression, failed to remove adequate disc material to promote fusion, failed to recognize misplaced cages after surgery,

failed to disclose complications to the patient, failed to schedule enough follow-up appointments, failed to properly evaluate post-op complaints, failed to keep adequate medical records, failed to record complications of surgery in medical records, and failed to address significant post-op complications in follow-up care.

In an extensive decision addressing each of the patients individually, the Board revoked AP's license to practice medicine.

DISCUSSION

The practice of medicine is not a natural or absolute right of individuals.[2] There is no property right to engage in the practice of medicine.[3] The right to practice medicine is a right granted on condition.[4] The state has the power to regulate the practice of medicine, and to establish and enforce standards of conduct relative to the health of its citizens.[5] It is well established that the state has a legitimate concern for maintaining high standards of professional conduct in the practice of medicine.[6] Recognizing that the practice of medicine is a privilege granted by the legislature, the state declared that,

> …..the state of Louisiana deems it necessary as a matter of policy in the interests of public health, safety, and welfare to provide laws and provisions covering the granting of that privilege and its subsequent use, control, and regulation to the end that the public shall be properly protected against unprofessional, improper, unauthorized, and unqualified practice of medicine and from unprofessional conduct of persons licensed to practice medicine….'[7]

---

[2] *Louisiana State Board of Medical Examiners v. Fife*, 1927, 162 La. 681, 685, 111 So. 58, *affirmed* 47 S.Ct. 590, 274 U.S. 720, 71 L.Ed. 1324.
[3] *Id*.
[4] *Id.*
[5] *Barsky v. Bd. of Regents of Univ.,* 347 U.S. 442, 452, 74 S.Ct. 650, 656, 98 L.Ed.829 (1954).
[6] *Louisiana State Bd. of Medical Examiners v. Fife, supra* 162 La. at 685.
[7] La. R.S. 37:1261.

To meet this objective the Louisiana State Board of Medical Examiners was established by La. R.S. 37:1263.

Review of a decision of an administrative body begins in the district court. A party aggrieved by a final agency decision in an adjudication proceeding is entitled to have that decision reviewed initially by the district court of the parish in which the agency is located.[8] "The general principle governing the review of the Board's decision by the district court is that, if the evidence, as reasonably interpreted, supports the agency's determinations, then the agency's orders are accorded great weight and will not be reversed or modified in the absence of a clear showing that the administrative action is arbitrary and capricious."[9] "A reviewing court should not set aside an administrative agency's decision to impose a particular sanction unless that decision can be characterized as arbitrary, capricious, or an abuse of discretion."[10]

Appeal of a district court's decision on review of the Board's decision can be made to the appropriate appellate court as in other civil cases.[11] "When an appellate court reviews the district court's judgment, no deference is owed by the appellate court to the district court's fact findings or legal conclusions, just as no deference is owed by the Louisiana Supreme Court to factual findings or legal conclusions of the court of appeal."[12] Thus, an appellate court sitting in review of

---

[8] La. R.S. 49:964(A)(1) and (B).
[9] *Mayeaux's Food & Sporting Goods, Inc. v. State, Dep't of Health & Human Res.*, 470 So.2d 469, 471 (La. Ct. App. 1985).
[10] *Clark v. Louisiana State Racing Com'n*, 2012-1049 (La. App. 4 Cir. 12/12/12), 104 So.3d 820, 827, *writ denied*, 2013-0386 (La. 4/1/13), 110 So.3d 589.
[11] La. R.S. 49:965.
[12] *Bourgeois v. Louisiana State Racing Comm'n,* 10-0573 (La.App. 4 Cir. 11/12/10), 51 So.3d 851, 856 (quoting *Smith v. State, Dep't of Health and Hospitals,* 39,368 (La.App.2d Cir.03/02/05), 895 So.2d 735, 739).

an administrative agency reviews the findings and ultimate decision of the administrative agency and not the decision of the district court.

"The exclusive grounds upon which an administrative agency's decision may be reversed or modified on appeal are enumerated in La. R.S. 49:964(G) of the Administrative Procedure Act ("APA")."[13] La. R.S. 49:964(G) provides that a court can reverse an agency's decision if the appellant's substantial rights have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

(1) In violation of constitutional or statutory provisions;

(2) In excess of the statutory authority of the agency;

(3) Made upon unlawful procedure;

(4) Affected by other error of law;

(5) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or,

(6) Not supported and sustainable by a preponderance of evidence as determined by the reviewing court.

The APA further provides that "[t]he agency's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence." La. R.S. 49:956(3).

In the application of this rule, the court shall make its own evaluation of the record reviewed in its entirety upon judicial review. "Where the agency has the opportunity to judge the credibility of witnesses by first-hand observation of

---

[13] *Armstrong v. Louisiana State Bd. of Medical Examiners,* 03-1241 (La.App. 4 Cir. 2/18/04), 868 So.2d 830, 837–38.

demeanor on the witness stand and the reviewing court does not, due regard shall be given to the agency's determination of credibility issues."[14]

Although a review of the district court's ruling is not mandated, out of an abundance of caution, that ruling was thoroughly reviewed by this Court as is reflected in this opinion. Upon review, we disagree with the district court that the Board conducted a fundamentally unfair hearing.

In the matter before us, the district court found the "totality of the improper actions of the Board resulted in a hearing conducted in violation of AP's constitutional due process rights, made upon unlawful procedure and clearly arbitrary and characterized by an abuse of discretion." However, the district court did not reverse or modify the Board's decision to revoke AP's license to practice medicine. Instead the district court remanded this matter to the Board for further proceedings. The district court agreed with AP that the hearing of the Board was not fundamentally fair.

In its reasons for judgment, the district court lists several improper and/or unlawful actions of the Board used to support the decision. The first relates to the initial basis for the inquiry into AP's competence in 2010. The court reasoned that, because the Board considered the Interim Consent Order, it should have allowed AP to present evidence to show that the basis of the initial complaint that led to the consent order was inaccurate.

We disagree with the trial court that further inquiry into the initial complaints against AP is necessary for fundamental fairness. AP was well aware of the allegations against him that led up to his consent to refrain from performing

---

[14] *Cathey v. Louisiana State Racing Comm'n*, 2003-0923 (La. App. 4 Cir. 9/24/03), 855 So.2d

the surgical procedure since 2010, and had ample opportunity to present evidence at the hearing to combat all allegations against him.

Next, the trial court found that the hearing officer "cut off" AP's attempt to qualify Dr. Robert Lieberson as an expert in minimally invasive TLIF surgery since he had only performed one procedure. The record of the Board does not support this finding. AP's counsel was given the opportunity to question Dr. Lieberson regarding his education, training, experience, teaching experience, publications, presentations at national meetings, as well as his consulting experience. Although, the hearing officer did not accept Dr. Lieberson as an expert in TLIF surgery since he had only performed one such procedure, the doctor was allowed to testify as an expert in general neurosurgery.

The district court took issue with the reference in the Board's decision to Dr. Anil Nanda's characterization of AP's actions as "moral blindness". This comment was cited by the Board in its consideration whether AP's post-operative care met the standard of care.

It is clear from the Board's decision that AP's post-operative care of his patients was of grave concern. The record of the administrative hearing shows sufficient evidence for that concern. There were several instances in which AP failed to assess and/or treat patients' post-op complaints. There were also instances in which AP failed to inform his patients that post-op tests revealed a problem with the surgery. On some occasions, information given to patients was directly opposite results shown by the post-op tests. AP assured some patients that everything was normal on the tests, when in fact the tests showed misplaced or

---

414, 418, *writ denied,* 2003-3153 (La. 1/30/04), 865 So.2d 86. See also La. R.S. 49:964(G).

migrated cages. Testimony from doctors who treated AP's patients after the TLIF showed that some of AP's patients required secondary surgeries to repair or mitigate the damage done in the TLIF. For some patients, the damage could not be repaired.

The experts who testified acknowledged that there are always risks in surgical procedures, and in this particular surgery there is a possibility that the cage could migrate out of the space created for it. However, this is readily discoverable by post-op tests, and must be reported to the patient. Given AP's penchant for misrepresenting the post-op facts to his patients, we do not find Dr. Nanda's description of AP's behavior as "moral blindness" to be inaccurate or unfair.

Other reasons cited by the district court for its finding that the overall process of the Board was unfair to AP include the concern that most of the experts called by the Board were direct economic competitors. Considering AP's practice and area of expertise, it is not surprising that physicians who would have the most knowledge of local accepted standards of practice would also be economic competitors. However, the hearing officer addressed this concern in the proceeding, and was satisfied that the testimony of the physicians was not tainted by any desire for economic gain. The hearing officer also considered AP's motion for mistrial relating to a comment overheard by one of the doctors on the panel, in which he implied hearing AP's testimony was unnecessary. The hearing officer denied that motion after assurance from the doctor that the comment was not made seriously and that he would fairly consider all of the evidence before making a decision.

As previously stated our review must afford considerable latitude to the decision of the Board. We must start with the presumption that the proceedings

and decision of the Board is legitimate.[15] The burden is on the appellant to demonstrate the grounds of reversal or modification.[16] We do not find AP has met this burden.

The record of the Board's proceedings in this matter is extensive and the evaluation of the evidence presented to the Board and reflected in the Decision and Order withstands our judicial review. Contrary to the district court's findings and the representations in AP's brief to this Court, we find the Board conducted a fair and thorough investigation and hearing before making the determination to revoke AP's license to practice medicine. We find no merit in AP's allegations that he was unfairly treated by the Board or that there were any violations of his constitutional rights. Further, we do not find any improper actions or unlawful procedures in the Board's hearings that amount to a clearly arbitrary or abusive revocation of AP's medical license. Nor do we find there is any need to remand this matter to the Board for additional proceedings. Accordingly, we reverse the ruling of the district court and reinstate the decision and order of the Louisiana State Board of Medical Examiners.

REVERSED; DECISION OF THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS REINSTATED

---

[15] *Holladay v. Louisiana State Board of Medical Examiners,* 96-1740 (La.App. 4 Cir. 2/19/97), 689 So.2d 718, *writ denied,* 97-0730 (La.5/1/97), 693 So.2d 740.
[16] *Id.*