ORDER OF THE BOARD

TO: JOSHUA E. FOREMAN, DDS
    c/o ROBERT ANDERTON, ATTORNEY
    900 CONGRESS AVENUE, SUITE 250
    AUSTIN, TX 78701

    SUZANNE FORMBY MARSHALL
    ADMINISTRATIVE LAW JUDGE
    300 WEST 15TH STREET, SUITE 504
    AUSTIN, TX 78701

At the regularly scheduled public meeting on November 18, 2016, the State Board of Dental Examiners considered the following items: (1) Proposal for Decision (PFD) regarding the above cited matter; (2) Staff’s recommendation that the Board adopt the present Order, regarding the Administrative Law Judge’s (ALJ) recommended sanction of Texas dental license number 23918 belonging to Joshua E. Foreman, DDS; and (3) Respondent’s recommendation, if any.

The State Board of Dental Examiners finds that after proper and timely notice was given, the above styled case was heard by an ALJ who made and filed a PFD containing the ALJ’s Findings of Fact and Conclusions of Law. The PFD was properly served on all
parties, and all parties were given an opportunity to file exceptions and replies as part of the record herein.

The State Board of Dental Examiners, after review and due consideration of the PFD and the parties’ recommendations, adopts all of the Findings of Fact and Conclusions of Law of the ALJ contained in the PFD, as if fully set out and separately stated herein. Further, all proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are herein denied.

The Board is changing the ALJ’s recommended sanction. A determination of the appropriate sanction is reserved to the Board. Rule 100.20(c), *Texas State Bd. Of Dental Exam’rs v. Brown*, 281 S.W.3d 692, 697 (Tex.App.—Corpus Christi 2009, pet. denied). The Board has broad discretion when deciding what penalty to impose, *Sears v. Texas State Bd. Of Dental Exam’rs*, 759 S.W.2d 748, 751 (Tex.App.—Austin 1988, no writ), and the Board is not required to treat sanction recommendations as presumptively binding in the way that agencies are required to treat findings of fact and conclusions of law. *Froemming v. Texas State Bd. Of Dental Exam’rs*, 380 S.W.3d 787, 792 (Tex.App.—Austin 2012, no pet.).

The Board welcomes recommendations of administrative law judges as to the sanctions to be imposed, but the Board is not bound by those recommendations. Rule 100.20(b). The Board has determined that the ALJ did not properly apply the Board’s disciplinary matrix as urged by Board staff. Instead, Board staff recommends the imposition of a five thousand dollar ($5,000.00) administrative fine, twenty-seven (27) hours of continuing education, a prohibition on Respondent utilizing a papoose-style restraint in his practice, a prohibition on Respondent treating patients under thirteen (13)
years of age for one (1) year after the adoption of the Order of the Board, and the jurisprudence assessment, based upon the conclusions of law provided by the ALJ in the PFD.

The ALJ found in conclusion of law (COL) number 5 that Respondent practiced dentistry in a manner that constituted dishonorable conduct during the treatment of Patients 1-3 and 5, in COL number 6 that Respondent failed to treat Patients 1-5 according to the standard of care, in COL number 7 that Respondent violated or refused to comply with a law relating to the regulation of dentists, in COL number 8 that Respondent misled Patients 1-5 as to the gravity of their dental needs, and in COL number 9 that Respondent persistently over-diagnosed and over-treated Patients 1-5.

As second tier violations of the disciplinary sections associated with Tex. Occ. Code § 263.003(a)(3), (4), and (10), Respondent’s violations justify the imposition of an administrative fine and continuing education, as well as the prohibitions restricting the scope and activities of Respondent’s practice. These violations taken together justify an administrative fine of five thousand dollars pursuant to the Board’s disciplinary matrix. Finally, all disciplinary actions taken by the Board should include a stipulation requiring completion of the online jurisprudence assessment pursuant to the disciplinary matrix. No mitigating factors exist to reduce or remove these suggested sanctions.

IT IS THEREFORE ORDERED THAT:

1. Respondent’s Texas Dental License No. 23918, issued to JOSHUA E. FOREMAN, in the State of Texas is hereby issued the sanction of a five-year PROBATED SUSPENSION.

2. Respondent SHALL pay an administrative monetary fine in the amount of five thousand dollars ($5,000.00) payable to the “Texas State Board of Dental Examiners” located at 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701-3942. The administrative monetary fine SHALL be paid in
full no later than six (6) months from the date of ratification of this Order by the Board.

3. Respondent SHALL complete a total of twenty-seven (27) hours of continuing education (CE) courses, which SHALL be completed within six (6) months of the effective date of this ASO. The twenty-seven (27) hours of CE courses completed SHALL be in the following areas:
   - Risk Management and Record-Keeping  Six (6) hours
   - Pediatric Diagnosis and Treatment Planning  Nine (9) hours
   - Ethics  Six (6) hours
   - Pediatric Behavior Management  Six (6) hours

   This CE SHALL be in addition to Respondent’s annual CE hours required for licensure by the Board.

All CE courses SHALL be approved in advance by Board Staff. It is the responsibility of Respondent to obtain such approval. Courses taken without prior approval and/or prior to the effective date of this ASO SHALL NOT satisfy the requirements of this ASO. Board Staff SHALL have the authority to reduce the number of CE days or hours based on course availability. Upon the successful completion of each course, Respondent SHALL provide complete documentation of the course completion to the Board.

4. Respondent is PROHIBITED from utilizing a papoose board or papoose style passive restraints on his patients or any future patients Respondent may treat in the state of Texas.

5. Respondent SHALL NOT treat minor patients under thirteen (13) years of age for a period of one year (1) after the adoption of this Order of the Board.

6. Respondent SHALL successfully complete the Jurisprudence Assessment-Board Order and submit proof of completion to Board Staff within thirty (30) days of the effective date of this Order. Respondent SHALL be responsible for all costs relating to compliance with this requirement.

STATE BOARD OF DENTAL EXAMINERS

Entered this 18th day of November, 2016.

Steven J. Austin, D.D.S., Presiding Officer
State Board of Dental Examiners
Attachment:  *Proposal for Decision, Docket No. 504-15-0513 (March 8, 2016).*
Kelly Parker  
Executive Director  
State Board of Dental Examiners  
333 Guadalupe, Tower 3, Ste. 800  
Austin, Texas 78701-3942

RE: Docket No. 504-15-0513; Texas State Dental Board of Dental Examiners v. Joshua E. Foreman, DDS

Dear Ms. Parker:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Suzanne Formby Marshall  
Administrative Law Judge

SFM/ls  
Enclosures

xc: Richard Gober, Staff Attorney, State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701 – VIA INTERAGENCY  
Nycia Deal, General Counsel, State Board of Dental Examiners, 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701 – VIA INTERAGENCY  
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TEXAS STATE BOARD OF
DENTAL EXAMINERS,
Petitioner

v.

JOSHUA E. FOREMAN, DDS,
TEXAS DENTAL LICENSE
NUMBER 23918,
Respondent

BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARINGS

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TEXAS STATE BOARD OF
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Petitioner

v.

JOSHUA E. FOREMAN, DDS,
TEXAS DENTAL LICENSE
NUMBER 23918,
Respondent

BEFORE THE STATE OFFICE
OF
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PROPOSAL FOR DECISION

The staff (Staff) of the Texas State Board of Dental Examiners (Board or TSBDE) brought this action seeking a five-year probated suspension\(^1\) of the dental license of Joshua E. Foreman, DDS (Respondent) for alleged violations of the Dental Practice Act and Board rules. \(^2\) The ALJ finds that the preponderance of the evidence establishes some of the violations alleged by Staff and recommends that the Board issue a five-year probated suspension of Respondent’s license.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction in this proceeding. Therefore, these matters are addressed in the findings of fact and conclusions of law without further discussion here.

\(^1\) In its Formal Complaint, Staff originally requested a suspension of Respondent’s license and other sanctions, including but not limited to administrative fines, continuing education, and patient restitution. See Staff’s Formal Complaint, p. 3. In Staff’s Closing Brief, Staff’s requested relief consisted of a five-year probated suspension of the dental license, with an administrative fine, required continuing education, and a jurisprudence examination. In Staff’s Response to Respondent’s Closing Brief, the requested relief was only a five-year probated suspension of the dental license. It appears that Staff has elected to seek only a probated suspension in this case. Even if the other relief was still intended by Staff at the closing of the record in this case, there was no evidence or argument offered to support the additional elements of relief originally requested. Therefore, the ALJ considers only the probated suspension to be requested.

\(^2\) The Dental Practice Act can be found in Texas Occupations Code (Code) § 251.001 et seq. The specific Code provisions alleged to have been violated are Code § 263.002(a)(3), (4), and (10). The Board rules alleged to have been violated by Respondent are found at 22 Texas Administrative Code (Tex. Admin. Code) §§ 108.2(d), (e); 108.7(1), (6); 108.8(c)(2)(A) and (C), (6), (8); 108.9(2)(B), (6), (11). The Board rules in this proposal for decision will be referred to as Board Rule or Rule 108.x. All citations to the Code and Board rules are to those provisions in effect at the time of the treatment at issue.
The hearing convened September 29, 2015, before Administrative Law Judge (ALJ) Suzanne Formby Marshall in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by Richard Gober, Staff Attorney. Respondent was represented by attorneys Robert Anderton and Mark Hanna. The record closed on January 8, 2016, upon the last filing in the parties' submission of post-hearing briefs.

II. DISCUSSION

A. Background

Respondent is a licensed dentist in Texas who practiced at the Smile Center-Park North in San Antonio, Texas, at the times relevant to this case. Staff complains of Respondent's treatment of five minor patients. Four of the patients were treated by Respondent in July, October, and November of 2009. One of the patients was treated in September of 2011. The patients were all Medicaid patients.3

B. Staff's Allegations

Staff's formal complaint listed nine allegations against Respondent that arose from his treatment of the five minor patients.

Patient 1

1. On July 22, 2009, Respondent failed in his duty of fair dealing and engaged in dishonorable conduct during the dental treatment of Patient 1 by seating stainless steel crowns on primary teeth A, E, F, and J without medical necessity of treatment as documented in radiographs and documentation.

2. Additionally, Respondent fell below the minimum standard of care by failing to make, maintain, and keep adequate dental records on Patient 1 because the records did not include findings and charting of the clinical and radiographic oral examination.

3 Tr. at 122.
Patient 2

3. On October 6, 2009, Respondent failed in his duty of fair dealing and engaged in dishonorable conduct during the dental treatment of Patient 2 by performing pulpotomies\(^4\) and seating stainless steel crowns on primary teeth A and B without medical necessity of the treatment as documented in radiographs and documentation.

Patient 3

4. On October 6, 2009, Respondent fell below the minimum standard of care during the dental treatment of Patient 3 by administering 3.5 carpules of 2% Lidocaine with Epinephrine, when the maximum dose for this patient was 2.7 carpules; seating stainless steel crowns with open margins on primary teeth B, L, and S; and performing a substandard pulpotomy on primary tooth S due to pulp paste extending outside the pulp chamber and down the distal root subgingivally.

5. Respondent also fell below the minimum standard of care by failing to make, maintain, and keep adequate records on minor Patient 3 because the records did not include findings and charting of the clinical and radiographic oral examination.

Patient 4

6. On November 3, 2009, Respondent fell below the minimum standard of care during the dental treatment of Patient 4 by performing a pulpotomy and seating a stainless steel crown on primary tooth T when the tooth should have been extracted.

Patient 5

7. On September 22, 2011, Respondent failed in his duty of fair dealing and engaged in dishonorable conduct during the dental treatment of Patient 5 by diagnosing fillings on primary teeth C, D, G, and H without medical necessity of the treatment as shown by the radiographs and documentation. Additionally, Respondent did not actually place the fillings on primary teeth C, D, G, and H, but charged the patient’s insurance provider for the work.

\(^4\) A pulpotomy is a “mini root canal” of a baby tooth, as testified by Dr. Danny Watts, Staff’s expert witness.
8. Respondent also fell below the minimum standard of care during the dental treatment of minor patient 5 because Respondent failed to use protective stabilization devices and techniques in accordance with the appropriate professional standards and guidelines, resulting in injury to the minor patient.

9. Also on that date, Respondent fell below the minimum standard of care by failing to make, maintain, and keep adequate records on minor patient 5 because the records did not include signed, written informed consent for treatment of primary care teeth D and G.

C. Applicable Law

The Dental Practice Act (the Act) regulates dentists.\(^5\) Section 263.002(a) of the Texas Occupations Code (Code) sets forth the grounds for disciplinary action against a dentist. If a licensed dentist is subject to disciplinary action, the Board may reprimand, issue a warning letter to, impose a fine or administrative penalty on, or place on probation with conditions a person whose license has been suspended, or revoke or suspend the license of the dentist.

Staff has alleged that Respondent has violated the Code because he: (1) practiced dentistry or dental hygiene in a manner that constitutes dishonorable conduct; (2) failed to treat a patient according to the standard of care in the practice of dentistry or dental hygiene; and/or (3) violated or refused to comply with a law relating to the regulation of dentists . . . .\(^6\)

Additionally, Staff has alleged that Respondent violated a number of the Board’s rules. The applicable law related to those allegations is set forth below.

Board Rule 108.2 relates to the obligation of a dentist to engage in fair dealing with his or her dental patients. Rule 108.2(d) provides that:

Neither the dentist nor his employee(s) shall mislead dental patients as to the gravity or lack thereof of such dental patient’s needs.

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\(^5\) Code § 251.001 \textit{et seq}.

\(^6\) Code § 263.002(a)(3), (4), and (10).
Board Rule 108.2(c) states:

A dentist shall not flagrantly or persistently overcharge, overdiagnose, or overtreat a patient. For this rule the meaning of the term ‘overcharge’ includes, but is not limited to, collecting or attempting to collect a fee without reasonable justification for any element of dental services provided to a patient that is in excess of the fee the dentist ordinarily charges to others for the same service.

A dentist is required to treat a patient according to the standard of care in the practice of dentistry.\(^7\) In essence, a dentist must conduct his or her practice in a “manner consistent with that of a reasonable and prudent dentist under the same or similar circumstance.”\(^8\) This standard of care is repeated in Board Rule 108.7, which addresses the minimum standard of care. The rule requires dentists to:

(1) maintain patient records that meet the requirements set forth in §108.8;\(^9\) and

... 

(6) maintain written informed consent signed by the parent or legal guardian of a the patient if the patient is a minor . . . . Such consent is required for all treatment plans and procedures where a reasonable possibility of complications the treatment planned or a procedure exists, and such consent should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.\(^10\)

Board Rule 108.8 establishes the requirements for dental records. Rule 108.8(c)(2)(A) requires documentation of radiographs taken and findings deduced from them.\(^11\) Rule 108.8(6) required documentation of medication and dosages given to the patient. Rule 108.8(8) requires documentation of written informed consent meeting the requirements of Rule 108.7(6).

\(^7\) Code § 263.002(a)(4).
\(^8\) 22 Tex. Admin. Code § 108.7.
\(^9\) 22 Tex. Admin. Code § 108.7(1).
\(^10\) 22 Tex. Admin. Code § 108.7(6). Although this rule was amended in September 14, 2010, paragraphs (1) and (6) were not changed in the amendment.
\(^11\) In 2009 and 2011 (the times when treatment was provided in this case), Board rule 108.8(c)(2) did not have a subsection (C), as pleaded by Staff.
Rule 108.9 is the Board rule on dishonorable conduct. Staff relies on §§ 108.9(2)(B), Section 108.9(2)(B), (6), and (11). In 2009, Rule 108.9(2) did not include any subsections and dealt with providing services to a drug or alcohol impaired person. Therefore, that rule does not apply to Respondent’s conduct for Patients 1-4. In 2011, Rule 108.9(2)(B) defined dishonorable conduct to include deception or misrepresentation in obtaining a fee. This section was not in effect in 2009 but was in effect in 2011. Therefore, it is applicable only with respect to Patient 5.

In 2009, Rule 108.9(6) provided that dishonorable conduct by a licensee was “conduct that has become established through professional experience as likely to disgrace, degrade or bring discredit upon him or her or the dental profession.” In 2011, subsection (6) stated that dishonorable conduct included “the failure to comply with applicable laws, rules, regulations, and orders—violates or refuses to comply with a law relating to the regulation of dentists, dental hygienists, or dental assistants; fails to cooperate with a Board investigation; or fails to comply with the terms of a Board Order.” Rule 108.9(11) provides that dishonorable conduct includes engaging in conduct “that has become established through professional experience as likely to disgrace, degrade, or bring discredit upon the licensee or the dental profession.”

Additionally, the SBDE Disciplinary Matrix is to be used in determining the appropriate sanction to be imposed for one or more established violations. Staff asserts that Respondent engaged in three main categories of violations: (1) failing in his duty of fair dealing and engaging in dishonorable conduct by over-diagnosis and over-treatment; (2) failing to meet the standard of care; and (3) failing to make, maintain, and keep adequate record-keeping violations. Staff claims that the first two types of violations should be considered as Second Tier violations because there was a risk of patient harm in that Respondent performed unnecessary work that damaged the teeth of patients; failed to diagnose an abscess and re-treated a tooth that should have been extracted; and used a papoose restrain when it was not indicated.

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12 Because this section was in effect in both 2009 and 2011, it is applicable to all five patients.
13 This section was not in effect in 2009 but was in effect in 2011. It is applicable only to Patient 5.
15 Staff’s Closing Brief at 1.
causing the patient to develop petechiae. Staff asserts that the third type of violation is a First Tier Sanction.

Additionally, Staff contends that there are a number of aggravating factors that must be considered in determining the appropriate sanction in this case: the risk of patient harm; the number of violations present over five patients; violations committed for material gain; and unnecessary work for profit performed on disadvantaged children. The Disciplinary Matrix lists the following aggravating and mitigating factors to be considered, if applicable in a case:

- Potential or actual patient harm
- Prior disciplinary action
- Prior violations of a similar nature
- Self-report or voluntary admission of violation
- Remedial measures taken to correct or mitigate harm
- Rehabilitative potential
- Level of competency exhibited over course of career
- Attempts to circumvent a statute or board rule
- Isolated or repeated violation
- Number of violations
- Cooperation with board investigation and response to board communication
- Material or financial gain from violation
- Involvement of, or impairment by alcohol, illegal drugs, or controlled substances
- Criminal conduct
- Other relevant circumstances.

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16 Staff’s Closing Brief at 13. Penalties for these Second Tier violations range from warning, reprimand or probated suspension with stipulations to denial, suspension of license, revocation of license or a request for the voluntary surrender of the license. Matrix at 4, 7.

17 Staff’s Closing Brief at 11. The sanction for this violation (as a violation of Code § 263.002(a)(10)) would be an administrative penalty ticket if it is a First Tier Violation. If it is considered to be a Second Tier Violation, the sanction would be a warning or reprimand with stipulations. Matrix at 13. If the violation is found to be under Code § 263.002(a)(4), the penalty for a First Tier Violation is a warning or reprimand with stipulations. If this violation is considered to be a Second Tier Violation, the sanction is warning, reprimand, or probated suspension with stipulations or the denial, suspension of license, revocation of license, or request for voluntary surrender. Matrix at 4.

18 Matrix at 2.
D. Evidence and Analysis

Staff presented the testimony of Danny Watts, D.D.S., M.S.D., who testified as an expert witness. 19 Respondent presented the testimony of James W. Orr, D.D.S., who also testified as an expert witness. 20 Respondent did not testify. The parties jointly offered eleven exhibits which were admitted into evidence.

1. Patient 1 21

a. Allegation 1 (failure in duty of fair dealing and engaging in dishonorable conduct by seating stainless steel crowns on primary teeth A, E, F, and J without medical necessity of treatment as documented in radiographs and documentation).

Dr. Watts testified that the records for Patient 1 reflect a diagnosis of proximal caries revealed by radiographic and clinical examination; stainless steel crown (SSC) indicated, for primary tooth A. 22 The record indicates that Respondent removed extensive occlusal and interproximal 23 caries through the dentin; 24 prepared and fitted a stainless steel crown; cemented the crown with Ketac; 25 and checked the occlusion. Dr. Watts was asked to review the findings and charting of Respondent. 26 Dr. Watts agreed that the clinical notes reflected that the patient was very susceptible to decay. 27 If Respondent had found cuspal caries in his clinical examination, indicating incipient decay, Dr. Watts agreed that the decay should have been taken care of. 28 However, he was unable to determine whether such decay was actually found by the Respondent.

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19 The curriculum vitae for Dr. Watts is found in Joint Exhibit 10.
20 Dr. Orr is a former Board member. Tr. at 130. His curriculum vitae is found in Joint Exhibit 11.
21 See Joint Ex. 1.
22 Joint. Ex. 1 at 35.
23 Interproximal decay is a dark area of decay between the teeth. Tr. at 17. Interproximal refers to the two surfaces where two teeth touch each other.
24 Dr. Watts testified the dentin is the second layer of the tooth under the enamel.
25 This seems to be the name of the cementing substance used in securing the crowns.
26 Tr. at 107; Joint Ex. 1 at 34, 35, 49.
27 Tr. at 108.
28 Tr. at 109.
For teeth A, E, F, and J, Dr. Watts said that no interproximal decay was visible on the radiograph.\textsuperscript{29} In reviewing the radiograph for Tooth A, Dr. Watts noted that there was no interproximal decay on that tooth. The outside surface of enamel is brighter white than the dentinal layer, which is more grayish in color. Decay should have been visible from the radiograph. Because there was no indication of decay using the objective standard of a radiograph or there was an insufficient amount of decay requiring a crown, Dr. Watts testified that there was no medical justification for the use of a crown on Tooth A.

With respect to Tooth E, Dr. Watts noted that Respondent’s diagnosis was the same as that of Tooth A: “[r]adiographic and clinical exam revealed proximal caries. SSC indicated.”\textsuperscript{30} Respondent’s note reflects that he removed extensive occlusal and interproximal caries through the dentin; prepared and fitted the SSC; cemented the crown with Ketac and removed excess; and checked occlusion. Dr. Watts testified that there were no occlusal surfaces on Tooth E.\textsuperscript{31} This caused Respondent’s finding of “extensive” occlusal decay to be unreliable. Moreover, there was no caries on the radiograph for Tooth E. He said that if Respondent found caries during his clinical exam of Tooth E, he should have recorded that in his record. Moreover, since decay was not shown on the radiograph, Dr. Watts believed that such decay, if any, would have been so small that it would not have justified placement of a stainless steel crown. Dr. Watts testified that in his opinion, there was no justification for a stainless steel crown on Tooth E due to the lack of decay. The diagnoses for Teeth F and J (and Respondent’s actions) were the same as those for Teeth A and E. Dr. Watts further testified that there was no extensive interproximal and occlusal decay on either Tooth F or J and that neither should have been treated with a crown.

Dr. Orr disagreed with the Board’s allegation regarding Patient 1 because he believes that radiographs have scientific, dental, and health limitations. He said that the records he reviewed were within the minimum standard of care.\textsuperscript{32} Dr. Orr testified that decay does not always show

\textsuperscript{29} Tr. at 112; Joint Ex. 1 at 49.

\textsuperscript{30} Joint Ex. 1 at 35.

\textsuperscript{31} Dr. Watts testified that “occlusal” means the chewing surface of the tooth. The tooth has a flat surface that is used to mash food. In contrast, incisal teeth (cuspids and incisors in the front) have incisal edges and cusp tips on the pointed teeth which is used as “[t]he knife part of your chewing surface.” Tr. at 22.

\textsuperscript{32} Tr. at 133-134.
up on an x-ray so a dentist is supposed to use instruments, his eyes, and a clinical examination in addition to radiographs to get a complete picture of the tooth’s condition. Radiographs and documentation, he stated, are tools to assist in making a diagnosis. Dr. Orr believes that Respondent used these tools correctly.

b. Allegation 2 (failing to comply with the minimum standard of care with respect to making and maintaining adequate dental records because the records lacked findings and charting of the clinical and radiographic oral examination).

With respect to the records, Dr. Watts testified that they should reflect the reality of the situation, specific to that person. An adequate record consists of more than just having notations in charts or notes without an explanation of the situation. Respondent’s records reflect that he removed extensive occlusal and interproximal caries “every time” a stainless steel crown was done, making the records look like a cookie-cutter description of what treatment was done. Because the entries were identical for each tooth and did not take into account the appropriate working surfaces of each tooth, the entries are not reliable. Dr. Watts testified that the term “extensive” means “a good ways towards the pulp.” That degree of decay, he said, would more than likely show up on an x-ray.

When asked to describe whether a record was considered adequate when it repeatedly showed something that did not “match up” when compared to the objective reality, Dr. Watts testified the record would be considered inadequate because it did not explain the discrepancy.

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33 Tr. at 134.
34 Tr. at 134.
35 Tr. at 135.
36 Tr. at 110.
37 Tr. at 110.
38 Tr. at 111.
39 Tr. at 112.
40 Tr. at 112.
41 Tr. at 113.
Moreover, when that situation happens repeatedly, as in this case, this caused Dr. Watts to not rely on the record but to rely on the objective reality, as evidenced in the radiographs.\(^{42}\)

Dr. Orr believes there was adequate charting in the case that included correct findings.\(^{43}\) He said that even if Respondent used a template or cookie cutter description, the records could still meet the standard of care if the findings, charting, and clinical radiographic examination were present in the records.\(^{44}\)

**c. Analysis**

The preponderance of the evidence supports a finding that Respondent failed to treat Patient 1 according to the minimum standard of care in his treatment of primary teeth A, E, F, and J because no medical necessity for placing stainless steel crowns on these teeth was supported by the documentation. The Board considers the failure to make, maintain, and keep adequate dental records to also be part of the standard of care for dentistry,\(^{45}\) as well as a violation of the law relating to the regulation of dentists.\(^{46}\) It is also considered to be dishonorable conduct.\(^{47}\) Moreover, because Respondent’s records do not accurately state the nature and extent of treatment needed by the patient, Respondent violated the Board rule related to the duty of fair dealing by over-diagnosing and over-treating the teeth.\(^{48}\)

Respondent’s records have a “canned appearance,” as Dr. Watts testified, because the same diagnosis was listed for each tooth, and it also appears that the same treatment was provided for each tooth. And, even if the use of “canned” or computer-generated records is acceptable, Respondent should have provided specific information for each tooth to explain discrepancies between the radiographs and his clinical exams.

\(^{42}\) Tr. at 113.

\(^{43}\) Tr. at 135.

\(^{44}\) Tr. at 136.

\(^{45}\) Code § 263.0102(a)(4).

\(^{46}\) Code § 263.002(a)(10).

\(^{47}\) Board Rule 108.9(6). Therefore, Respondent also violated Code § 263.002(a)(3).

\(^{48}\) Board Rule 108.2(d) and (e) This analysis applies to all the patients for whom Staff alleges a records violation.
The problem is that the diagnosis of decay, especially extensive interproximal decay, was not reflected in the radiographs. Because the radiographs did not reflect the amount of decay or even some level of decay that would have supported the treatment provided to Patient 1, Respondent’s records should have done so. Although Respondent’s charting shows that various items are circled on the diagram of teeth,\(^{49}\) there is nothing to accompany the chart to explain what Respondent actually found during his clinical examination, with the exception of his notes.\(^{50}\)

Respondent’s notes are suspect because they were identical for seven of Patient 1’s teeth, including Teeth A, E, F, and J. While Respondent may have found the exact same situation for each of these teeth, he needed to document more information that explained the discrepancy between the radiograph and his clinical exam or at least what he found during his examination that made him conclude that a crown was necessary. The mere fact that Respondent’s records contain charting, notes, and radiographs is not sufficient to support the medical necessity of his treatment or to establish adequate records. Rule 108.8(C)(2)(A) requires documentation of radiographs and findings deduced from them (emphasis added). There is no documentation of Respondent’s findings deduced from the radiographs. And, such findings would have not supported the treatment given to Patient 1’s teeth, given the lack of visible decay.

The following comments are applicable to all the patients in this case. In general, the testimony of Dr. Watts and Dr. Orr was consistent as to each of the patients. Dr. Watts believed that Respondent’s diagnosis and treatment of the patients’ teeth, including performing pulpotomies and seating crowns was not based on objective evidence that the treatment was needed due to the lack of decay present in the radiographs and the lack of specific documentation that demonstrated there was decay sufficient to justify the treatment. Because Respondent did not testify, it is not known what he actually observed during his clinical examination that could have explained his treatment decision or clarified the records. Without this information, the ALJ could only consider the information as stated in the records and the two expert witnesses’ testimony.

\(^{49}\) Joint. Ex. 1 at 34.

\(^{50}\) Joint Ex. 1 at 35.
On the other hand, Dr. Orr seemed to take the position that so long as Respondent had radiographs, charts, and a clinical exam recorded in his records, this was sufficient to meet the minimum standard of care, regardless of whether there were discrepancies among them.

The ALJ finds Dr. Watts’s testimony to be more persuasive than that of Dr. Orr. Dr. Watts gave specific examples to explain his conclusion, carefully discussing the nature of each tooth and why the radiograph and documentation for the teeth did not support Respondent’s treatment. In contrast, Dr. Orr spoke in generalities without specifically referencing the teeth or their characteristics or explaining the basis for his conclusory testimony that Respondent met the minimum standards of care for treatment and documentation. Consequently, the ALJ has concluded that the testimony of Dr. Watts is more credible and should be given more weight in this case than the testimony provided by Dr. Orr.

In summary, Respondent violated Code § 263.002(a)(3), (4), and (10). Additionally, Respondent violated Board Rules 108.2(d) and (e), 108.7(1), and 108.8(c)(2)(A).

2. Patient 2

a. Allegation 3 (failing in the duty of fair dealing and engaging in dishonorable conduct by performing pulpotomies and seating stainless steel crowns on primary teeth A and B without medical necessity of the treatment as documented in radiographs and documentation).

Dr. Watts testified that Respondent’s diagnoses and treatment for both Tooth A and B were the same: “[r]adiographic and clinical exam revealed proximal caries. SSC indicated. Removed extensive occlusal and interproximal caries through the dentin. Prepared and fitted

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51 The ALJ notes that Code § 263.002(a)(3) refers to dishonorable conduct, a subject that is also defined in Board Rule 108.9, which states that “dishonorable conduct” includes, among other things, the violation or refusal to comply with a law relating to the regulation of dentists . . . which is identical to Code § 263.002(a)(10). So, Respondent’s failure to comply with the Board’s rule relating to documentation can essentially violate Code § 263.002(a)(3) and (10), as well as Board Rule 108.9(6) at the same time. However, Board Rule 108.9(6) contained different language in 2009.

52 As noted earlier, Rule 108.9 in effect in 2009 does not contain language that would support a finding of a violation for this patient.

53 The records for Patient 2 are in Joint Exhibit 2.
stainless steel crown. Cemented with Ketac and removed excess. Checked occlusion.\textsuperscript{54} Respondent also noted for Teeth A and B\textsuperscript{55} that "[S]evere decay encroached on the pulp. Pulpotomy completed. Placed ZOE in chamber."\textsuperscript{56}

Although Dr. Watts had difficulty initially identifying which tooth was A on the radiographic for this patient, he noted that there was no significant occlusal decay and no interproximal decay.\textsuperscript{57} Dr. Watts also stated that there was no severe decay encroaching into the pulp, although it was not clear whether he was referring to both teeth or only one.\textsuperscript{58} Dr. Watts did not agree that there was decay on either tooth A or B.\textsuperscript{59} According to Dr. Watts, a pulpotomy and stainless steel crown on Tooth A was not justified because the decay was "not even a third of the way through the dentin."\textsuperscript{60} Although Respondent's records state that he found severe decay using the explorer (an instrument with a sharp end used to probe the teeth) during a clinical exam and that the decay encroached on the pulp, Dr. Watts testified this is not believable because the decay does not show up on the x-ray and decay that big, which would justify a pulpotomy, would appear on the x-ray.\textsuperscript{61} He agreed that it is possible for a large amount of decay to be in a tooth without it showing on an x-ray, but he said that this is not a situation that would happen time and again, such as on teeth A and B, especially because there is a good x-ray of the teeth.\textsuperscript{62}

Dr. Watts observed that during the appointment for Patient 2 on October 6, 2009, Respondent worked on eight teeth.\textsuperscript{63} Respondent performed 4 pulpotomies in approximately 20 minutes, a time frame that Dr. Watts said was very fast for eight teeth.\textsuperscript{64} Due to the process involved, Dr. Watts concluded that a stainless steel crown may have been justified for Tooth A

\textsuperscript{54} Joint Ex. 2 at 51; Tr. at 24.

\textsuperscript{55} He also noted this for Teeth I and J.

\textsuperscript{56} Dr. Watts testified that ZOE referred to medication that goes inside the tooth for a pulpotomy, or "mini-root canal," on a baby tooth. Tr. at 25.

\textsuperscript{57} Tr. at 25-26.

\textsuperscript{58} Tr. at 26.

\textsuperscript{59} Tr. at 102.

\textsuperscript{60} Tr. at 26.

\textsuperscript{61} Tr. 103-04.

\textsuperscript{62} Tr. at 104.

\textsuperscript{63} Dr. Watts described the teeth as the first and second primary molars, all four quadrants. Tr. at 29.

\textsuperscript{64} Joint Ex. 2 at 60; Tr. at 32, 33.
and B if more information had been recorded, such as the presence of decalcification or hypoplastic enamel, because interproximal decay was not visible, but Respondent did not record such information. Without the additional information, Dr. Watts concluded that the pulpotomies were not justified.

Dr. Orr did not agree that pulpotomies and crowns were not medically necessary on Patient 2.\textsuperscript{65} Dr. Orr found the documentation for teeth A and B to be adequate. Even though decay was not present on the radiographs, he said that Respondent’s clinical examination indicated that decay was there, and the lack of it on the radiographs does not mean it was not there.\textsuperscript{66} He agreed\textsuperscript{67} that “we” could assume that Respondent was telling the truth because there was no indication in the records that he was not.\textsuperscript{68} If there was extensive decay once Respondent opened up the teeth, it would have indicated that a pulpotomy was necessary. Consequently, the treatment was within the standard of care.\textsuperscript{69}

Dr. Orr disputed that he said that an x-ray is not going to detect decay that is reported clinically, saying that it is very possible it would do so, “but I would not agree that that’s what you will find. I’ve been caught too many times in the opposite situation.”\textsuperscript{70} When asked to review the radiograph, Dr. Orr said he could not see severe decay. However, he said he did not think very highly of those radiographs because they were barely of a minimum quality.\textsuperscript{71} Moreover, he added that he does not read paper radiographs.\textsuperscript{72} After being directed to look at Respondent’s records for Tooth A, B, I, and J, Dr. Orr said that he could not say whether they said the exact same thing because “I didn’t read it for that.”\textsuperscript{73} When asked if adequate clinical

\textsuperscript{65} Tr. at 136.

\textsuperscript{66} Tr. at 137.

\textsuperscript{67} Most of the questioning on direct examination of Dr. Orr was through the use of leading questions, where the witness does not provide his own answer.

\textsuperscript{68} Tr. at 137.

\textsuperscript{69} Tr. at 138.

\textsuperscript{70} Tr. at 154.

\textsuperscript{71} Tr. at 155; Joint Ex. 2 at 77.

\textsuperscript{72} Tr. at 155.

\textsuperscript{73} Tr. at 157; Joint Ex. 2 at 51. The ALJ notes that these entries were made one after the other on one sheet of paper, making it very easy for the reader to see that they were identical.
notes would include specific details about each tooth, Dr. Orr said they would not necessarily be different from each other. Nor would they have to reasonably reflect some form of objective proof because Dr. Orr said that the chart allowed the dentist to do that.

b. Analysis

Essentially, the same chart entry appeared in Respondent’s records for each tooth treated on October 6, 2009, for this patient, with the exception of the additional note of “severe decay encroached on pulp; pulpotomy completed” which appeared for teeth A and B. The pulpotomies and stainless steel crowns for Teeth A and B were not medically necessary because the radiographic evidence did not reflect interproximal decay on either tooth, and even if there was a small amount of occlusal decay, it did not encroach upon the pulp. Dr. Watts testified that the decay on Tooth A was not even a third of the way through the dentin. There simply was not enough information in the record, including the chart and notes from the clinical exam, to support the medical necessity for the treatment given.

Additionally, the ALJ relies on the analysis of Patient 1 with respect to the testimonies of Dr. Watts and Dr. Orr for this patient as well. The preponderance of the evidence supports a finding that Respondent violated Code § 263.002(a)(3), (4), and (10). Additionally, Respondent violated Board Rules 108.2(d) and (e), 108.7(1), and 108.8(c)(2)(A).

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74 Tr. at 157.
75 Tr. at 157-58.
76 A total of eight teeth.
77 Joint Ex. 2 at 50-51.
78 The ALJ notes that Code § 263.002(a)(3) refers to dishonorable conduct, a subject that is also defined in Board Rule 108.9, which states that “dishonorable conduct” includes, among other things, the violation or refusal to comply with a law relating to the regulation of dentists , . . which is identical to Code § 263.002(a)(10). So, Respondent’s failure to comply with the Board’s rule relating to documentation can essentially violate Code § 263.002(a)(3) and (10), as well as Board Rule 108.9(6) at the same time. However, Board Rule 108.9(6) contained different language in 2009.
79 As noted earlier, Rule 108.9 in effect in 2009 does not contain language that would support a finding of a violation for this patient.
3. Patient 3

a. Allegation 4 (failing below the minimum standard of care by exceeding the maximum anesthetic dose for the patient; seating stainless steel crowns with open margins on primary teeth B, L, and S; and performing a substandard pulpotomy on primary tooth S.)

The diagnosis and treatment for Teeth B, L, and S, according to Dr. Watts, were the same as for other teeth of the other patients in this case: “[r]adiographic and clinical exam revealed proximal caries. SSC indicated. Removed extensive occlusal and interproximal caries through dentin. Prepared and fit stainless steel crown. Cemented with Ketac and removed excess. Checked occlusion.”

Dr. Watts testified that Respondent seated crowns on primary Teeth B and L with open margins on both sides of the crown. According to Dr. Watts, the standard of care requires that a dentist must seat a crown so that it fits the tooth and covers the margins of the tooth. He said that an open margin allows food to get in between the areas of the open margin, leading to decay. According to Dr. Watts, the crowns were too large for the teeth or they needed to be prepped differently. With respect to the pulpotomy done on Tooth B, Dr. Watts testified that he considered the pulpotomy to be a failure. He said the quality of care was not very good. He noted that there was resorption of the root because the tooth had not yet abscessed. In explaining where the margin on this crown should be, Dr. Watts explained where the margin on this crown should be, noting that the crown could be crimped in order to contour it to fit the tooth. Dr. Watts said that it was more about the contours of the crown over the tooth. Dr. Watts considered the pulpotomy procedure and the open margin of the crown to be below the standard of care, based on his observations of the radiograph.

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80 Tr. at 36-37, 42-43; Joint Ex. 3 at 47, 73.
81 He described an open margin as “the space between where the crown edge finishes and where the tooth begins.” Tr. at 42.
82 Tr. at 42-43.
83 Resorption is the normal process that occurs when a permanent tooth pushes out a baby tooth, causing the root of the baby tooth to resolve. Tr. at 45.
84 Tr. at 115.
85 Tr. at 117.
With respect to the open margins on the crown of Teeth B, Dr. Watts was asked whether something could have happened in the time since when it was first placed on Tooth B that could have created an open margin like the one appearing in the radiograph taken in November 2010.\textsuperscript{86} Dr. Watts testified that the crown did not fit properly from the beginning. It was not correct to say that all stainless steel crowns have open margins, he said, but the standard of care allows less than a millimeter of open margin.\textsuperscript{87} When asked about crowns on other teeth (Teeth A and T) which were not the subject of the allegations against Respondent, Dr. Watts testified that he believed those were not within the standard of care either. After continued questioning on cross-examination about whether all stainless steel crowns have open margins, Dr. Watts said, “But they don’t look like socks on a rooster, and that’s what this looks like.”\textsuperscript{88}

Tooth L also has an open margin on both sides of the crown.\textsuperscript{89} Dr. Watts described this as not as severe as on Tooth B, but he said “it still has issues” because food could get trapped and there is calculus on the tooth.\textsuperscript{90} The root of this tooth goes at an angle. Dr. Watts said that the crown doesn’t sufficiently “get down to where it’s supposed to be,” because there is exposed root that needs to be covered by the crown. In his opinion, the crown was either trimmed too short or prepped too far.\textsuperscript{91}

On Tooth S, Dr. Watts testified that there was a little “foot” or extension coming down from the edge of the crown that consisted of cement coming from under the crown.\textsuperscript{92} Dr. Watts said that the pulpotomy was below the standard of care and that it would have been better to remove the tooth because the stainless steel crown would not go far enough down to cover the exposed root area of the tooth. He said it was “questionable” whether the tooth needed to be

\textsuperscript{86} Joint Ex. 3 at 70; Tr. at 84-85.
\textsuperscript{87} Tr. at 85-86. Dr. Watts noted that there were other crowns on Patient 3 that fit fine. Dr. Watts also referred to the standards of the American Academy of Pediatric Dentistry in terms of the standards for open margins on stainless steel crowns, saying that there is not a specific number, but that a crown “should be as contoured and as closed as necessary, not where they cause food traps.” Tr. at 87.
\textsuperscript{88} Tr. at 89.
\textsuperscript{89} Tr. at 43; Joint Ex. 3 at 73.
\textsuperscript{90} Tr. at 43. Calculus refers to tartar build-up.
\textsuperscript{91} Tr. at 117-18.
\textsuperscript{92} Tr. at 43-44. Dr. Watts stated that the cement was probably Ketac because it hardens and has to be scraped off the tooth. Pulp paste is a softer substance that gets absorbed.
saved at all. Dr. Watts said that the “prep” for the crown came all the way down to the root of the tooth and that the tooth was not savable at that point. In discussing the standard of care, Dr. Watts said that he was taught to do no harm when it came to margins. He said that it is all about “managing risk.” While the open margins may not cause too much harm, he believed it was not consistent with the practice of managing risk. Dr. Orr testified that he did not know what the material was that extended outside the pulp chamber and no one else did, either, but that he did not believe it was causing any harm at all. He also did not believe the situation violated the standard of care.

After looking at x-rays taken on June 3, 2011, Dr. Watts was asked about the spaces where teeth B, L, and S used to be. Dr. Watts testified that the spaces indicate where the bicuspid were going to erupt into that space. He said that the space left where Tooth B had been was not adequate for the coming tooth. Dr. Watts said that the space for Tooth S looked adequate, so long as the tooth did not catch on the margins of Tooth K. When asked whether there was harm to the patient from the pulpotomies and crowns on teeth B, L, and S, Dr. Watts said he could not answer because it would be necessary to wait until the permanent teeth came in. When questioned about whether the crowns could have met the standard of care if their purpose was to make the teeth last for six or seven months (or even a year), Dr. Watts testified that he did not believe there was a stated standard of care on how long a tooth is supposed to stay in place.

In discussing the medications used on Patient 3, Dr. Watts said that the patient weighed 50 pounds and the appropriate amount of lidocaine for a patient that size is 1.5 to 2.0 milligrams.

93 Tr. at 47.
94 Tr. at 118.
95 Tr. at 119.
96 Tr. at 119.
97 Tr. at 142.
98 Joint Ex. 3 at 76; Tr. at 90-91.
99 Tr. at 91.
100 Tr. at 91.
101 Tr. at 93.
per pound.\textsuperscript{102} Noting that the Respondent’s record referred to the amount of medication by
carpule, he said that one carpule has 34 milligrams, making the amount given to the patient to be
equivalent to 119 milligrams. Dr. Watts testified that the maximum dose for a 50-pound patient
is 100 milligrams.\textsuperscript{103} When asked whether that could “potentially” be below the standard of
care, Dr. Watts said that it was over what was recommended as the dosage level.\textsuperscript{104} When
questioned about a hypothetical situation in which he was working on a child who had been
given the maximum dose of anesthetic and the child was starting to feel pain, would he give a
small amount further of anesthetic to the child in order to finish the treatment or abort the
treatment, Dr. Watts testified that he would not have initially given as much anesthetic to the
child so he would not run into that dilemma.\textsuperscript{105} When pressed further, Dr. Watts testified that he
would not exceed the maximum limit of anesthetic.\textsuperscript{106} Although he said that nothing indicated
the child was harmed, Dr. Watts said there was a risk of harm to the child from the anesthetic
dose.\textsuperscript{107}

Dr. Orr agreed that there were open margins on teeth B, L and S.\textsuperscript{108} He agreed that a
stainless steel crown necessarily has open margins and that it was not beneath the standard of
care to have open margins.\textsuperscript{109} When asked to describe the process of fitting a stainless steel
crown, Dr. Orr testified, “... I’m sure it concerns the fitting and customization of a stock crown
so that it fits the situation within the priorities of a reasonable and prudent dentist.”\textsuperscript{110}

Dr. Orr testified that there may be instances where exceeding the maximum dose of an
anesthetic could be acceptable, saying that he has done that before.\textsuperscript{111} When asked whether he

\textsuperscript{102} Tr. at 47.
\textsuperscript{103} Tr. at 48.
\textsuperscript{104} Tr. at 58.
\textsuperscript{105} Tr. at 98.
\textsuperscript{106} Tr. at 99.
\textsuperscript{107} Tr. at 100.
\textsuperscript{108} Tr. at 140.
\textsuperscript{109} Tr. at 141.
\textsuperscript{110} Tr. at 141.
\textsuperscript{111} Tr. at 139. However, when asked to give an example, Dr. Orr said “[t]here could be clinical situation that one
could devise to say that, yes sir. And I have probably been there.”
would continue when a patient was coming to the end of a lengthy procedure and feeling pain and the dentist could continue by giving the patient a few more drops of anesthetic, Dr. Orr responded that with several limitations, he probably would do so. 112 On cross-examination, Dr. Orr testified that if he was faced with the choice of completing the crown and having to exceed the anesthetic dose “or temporizing the tooth and living to fight another day,” the answer would depend on the patient, their health, and what they give me permission to do.” 113 He did agree that in most cases, it probably would be better to temporize. 114 Dr. Orr agreed that working on 12 different teeth in four quadrants of the mouth, as Respondent did for Patient 3, is a large amount of work, by any criteria. 115 Dr. Orr also agreed that exceeding the normal dose of anesthetic, under certain circumstances, would not be beneath the standard of care and that giving the patient 4/10 of a carpule is a very small amount when considered over the length of time of the treatment. 116

b. **Allegation 5** (failing to meet the minimum standard of care with respect to the dental records because they did not include findings and charting of the clinical and radiographic oral examination).

With respect to the findings and charting for Patient 3, Dr. Watts disputed that the phrase “radiograph and clinical examination revealed proximal caries” was a finding because it was not proven up with the radiographic imaging. 117 Dr. Watts also disputed that Respondent’s chart of Patient 3’s teeth was a chart of findings because he said that the markings on the chart did not tell him anything. 118 Dr. Watts said that even if the information contained further within the exhibit were considered to be Respondent’s findings and charting, that Respondent did not meet the standard of care. 119

112 Tr. at 139. He described the limitations as being things such as patient permission, health situation, patient’s blood pressure, and the particular dental surgery being performed.

113 Tr. at 160.

114 Tr. at 160.

115 Tr. at 163.

116 Tr. at 166.

117 Tr. at 95.

118 Tr. at 96; Joint Ex. 3 at 46.

119 Tr. at 97; Joint Ex. 3 at 46-47.
Dr. Orr testified that he did not agree with the allegation about Patient 3’s records being inadequate. He said the charting and clinical findings were adequate “with certain professional reservations.” But, he agreed they met the Board’s requirements. He believes all the allegations regarding Respondent’s care of Patient 3 to be without merit.

c. Analysis

The evidence established that Respondent failed to meet the minimum standard of care for Patient 3 by seating stainless steel crowns on Teeth B, L, and S with open margins, performing a substandard pulpotomy on Tooth S due to a foreign substance extending outside the pulp chamber and down the distal root subgingivally, and administering an anesthetic in a dosage that exceeded the maximum dose for Patient 3’s size.

As in the case of Patients 2 and 3, Dr. Watts’s expert testimony was more credible than that of Dr. Orr. Dr. Watts explained the problems with the crowns on Teeth B and L, i.e., that they had open margins which would cause food to become trapped, leading to decay. Dr. Orr conceded that there were open margins, but opined that the crowns still met the standard of care without explaining how they did so. Moreover, Dr. Orr’s knowledge of the fitting of stainless steel crowns appeared to be minimal, thereby diminishing his credibility on this topic. The crown on Tooth S is especially troubling, given that no crown would have been able to cover the exposed root area of the tooth. It appears from the credible evidence that Respondent should have removed the tooth instead of attempting to restore it.

With respect to the allegation regarding Respondent’s use of more than the maximum dose of anesthetic for Patient 3, Dr. Watts testified this violated the standard of care. He said that he would not have administered the maximum dosage because sometimes unexpected things happen and it might be necessary to give more. Dr. Orr suggested that it might be appropriate to do as Respondent had done, although he said it would depend on the circumstances, but he did not describe any circumstances that would justify exceeding the maximum anesthetic dose.

120 Tr. at 143.
121 Tr. at 144.
122 Tr. at 144.
Giving Patient 3 an excessive dose of anesthetic during a procedure involving treatment of twelve teeth in four quadrants of the mouth exposed the patient to an unnecessary risk of harm and is below the standard of care. While Staff argued in closing that Respondent’s treatment decisions were related to the fact that the children were Medicaid patients, there was simply no specific evidence to support this conclusion. Dr. Watts did not testify he believed the treatment of these patients was related to their status as Medicaid patients. Consequently, the ALJ does not find that this was proved to be a relevant issue in this case with respect to any patient.

Additionally, Respondent’s records were not adequate because they did not include findings and charting of the clinical and radiographic exam. The analysis related to the record is the same as that for Patients 2 and 3 and will not be repeated here.

In summary, the preponderance of the credible evidence established violations of Code § 263.002(a)(3), (4), and (10). Additionally, Respondent violated Board Rules 108.2(d) and (e), 108.7(1), and 108.8(c)(2)(A).

4. Patient 4

a. Allegation 6 (failing to comply with the minimum standard of care by performing a pulpotomy and seating a stainless steel crown on primary tooth T when the tooth should have been extracted).

Dr. Watts testified about Tooth T and records from two visits: April 17, 2009 and November 3, 2009. As to April 17, 2009, Dr. Watts said that Respondent’s records reflect that he “[r]emoved extensive occlusal and interproximal caries through dentin. Prepared and fit

123 The ALJ notes that Code § 263.002(a)(3) refers to dishonorable conduct, a subject that is also defined in Board Rule 108.9, which states that “dishonorable conduct” includes, among other things, the violation or refusal to comply with a law relating to the regulation of dentists... which is identical to Code § 263.002(a)(10). So, Respondent’s failure to comply with the Board’s rule relating to documentation can essentially violate Code § 263.002(a)(3) and (10), as well as Board Rule 108.9(6) at the same time. However, Board Rule 108.9(6) contained different language in 2009.

124 As noted earlier, Rule 108.9 in effect in 2009 does not contain language that would support a finding of a violation for this patient.

125 The November 3, 2009 visit is the subject of Staff’s allegations. The purpose of testimony about the April 2009 visit was to compare the records and condition of the teeth at both visits.

126 Joint Ex. 32; Tr. at 48-51.
stainless steel crown. Cemented with Ketac and removed excess. Checked occlusion.” Additionally, Respondent noted in the records that “[S]evere decay encroached on pulp. Pulpotomy completed. Placed ZOE in chamber.”

When asked to review the pre-operative radiograph of Tooth T, Dr. Watts observed that it showed some decay on the top, with normal bone in the furcation (at the bottom of the two roots where they join). Dr. Watts agreed that some occlusal decay showed on the radiograph, as well as a deep groove that indicates there was probably something soft at the center. Dr. Watts said that the tooth needed “something.” However, the post-operative radiograph revealed that there was a dark area in the furcation that Dr. Watts testified would start dissolving, indicating a failure of the pulpotomy on the tooth.

On November 3, 2009, Respondent treated Tooth T with another crown and pulpotomy. When asked whether it was typical to perform two pulpotomies on the same tooth, Dr. Watts testified that it would be done only if there had been a failure of the first one and the dentist was trying to save the tooth. However, Dr. Watts said that the standard of care in that situation would have been to remove the tooth because “[t]he success rate is substandard for trying to redo” a pulpotomy. Because there was an abscess in the furcation, Dr. Watts said that the chronic infection would not be healthy for a permanent tooth that is forming below the abscess. It could cause the enamel on the forming permanent tooth to become defective or hypoplastic and discolored. Although Dr. Watts agreed that one option in saving the tooth was to try to preserve the first permanent molar's eruption, he said it was a high risk and that he was not sure whether it was within the standard of care. He said that the standard of care when a tooth is

127 Joint Ex. 32; Tr. at 48.
128 Joint Ex. 4 at 69; Tr. at 49.
129 Tr. at 79.
130 Tr. at 79.
131 Joint Ex. 4 at 69; Tr. at 49-50.
132 Tr. at 51.
133 Tr. at 52. Dr. Watts said the standard of care would have been to make a space for the removed tooth, if space maintenance was necessary. Tr. at 53.
134 Tr. at 52.
abscessed on a baby molar is to remove it.\textsuperscript{135} If there was no sign of any infection, then it might be an option to try to save the tooth for a few more months.\textsuperscript{136} Dr. Watts said he did not know the standard of care for treating a tooth that has abscessed because that is an atypical occurrence, although treatment of a condition that is outside the norm could possibly be within the standard of care.\textsuperscript{137}

Dr. Watts also testified that the treatment plan for the November visit should not have said that a stainless steel crown was necessary because the tooth already had one. Instead, Respondent should have stated that he was going to re-do the pulpotomy because it was failing and that he would replace the crown, if that was what he did; however, the record for the visit does not reflect that.\textsuperscript{138} Dr. Watts also disputed the entry referring to severe decay encroaching on the pulp because he said there was no decay in the tooth.\textsuperscript{139}

Dr. Orr testified that he agreed with Respondent’s decision to repeat the pulpotomy and attempt to save Tooth T.\textsuperscript{140} He said that a professional has the right to make choices “based on what we see at the moment with that patient.” And he said that the Board has no way of knowing what the situation was like at the time.\textsuperscript{141} Consequently, he believed the allegations regarding Patient 4 were without merit.

\textbf{b. Analysis}

Dr. Orr’s testimony regarding the repeat of a pulpotomy on Tooth T in an effort to save it was not supported by any rationale, but was based on speculation and conclusion. It also reflected a lack of a meaningful review of Respondent’s records. When Respondent first treated Tooth T in April of 2009, an abscess was not present. After the pulpotomy and restoration attempt began to fail, the radiographs showed the abscess but Respondent did not notice it or

\begin{itemize}
\item \textsuperscript{135} Tr. at 81-82.
\item \textsuperscript{136} Tr. at 82.
\item \textsuperscript{137} Tr. at 82.
\item \textsuperscript{138} Tr. at 53-54.
\item \textsuperscript{139} Tr. at 54. Dr. Watts said that this was an inaccurate diagnosis.
\item \textsuperscript{140} Tr. at 145.
\item \textsuperscript{141} Tr. at 146.
\end{itemize}
failed to document it in his records. Although Dr. Watts testified that the standard of care required the extraction of the tooth, Respondent elected to attempt another restoration, although his rationale for this action is not set forth in his notes. Extraction was appropriate for the tooth because of the chronic infection in the tooth that could affect the permanent tooth.

Staff did not allege that Respondent’s records were inadequate for Patient 4; accordingly, this will not be addressed. The preponderance of the evidence established that Respondent violated Code § 263.002(a)(4). Additionally, Respondent violated Board Rules 108.2(d) and (e).  

5. Patient 5

a. Allegation 7 (failing to comply with the duty of fair dealing and engaging in dishonorable conduct by diagnosing fillings on primary teeth C, D, G, and H without medical necessity of the treatment and charging the patient’s insurance provider for placing the fillings on the teeth when he did not do so).

Dr. Watts testified that Respondent’s records for Tooth C reflect a facial, one-surface composite, a resin, and a mesial incisal lingual (a three-surface composite) on the tooth. In reviewing the pre-operative radiographs of Tooth C, Dr. Watts said that there was no decay evident on the tooth. According to Dr. Watts, the record only described the treatment that Respondent was going to do, but did not describe where the decay was on the tooth that required the treatment. When questioned about whether the records indicated that Respondent performed a thorough clinical examination, Dr. Watts disagreed. He testified that the clinical examination was not thoroughly charted because it did not state where the decay appeared on the

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142 The ALJ notes that Code § 263.002(a)(3) refers to dishonorable conduct, a subject that is also defined in Board Rule 108.9, which states that “dishonorable conduct” includes, among other things, the violation or refusal to comply with a law relating to the regulation of dentists . . . which is identical to Code § 263.002(a)(10). So, Respondent’s failure to comply with the Board’s rule relating to documentation can essentially violate Code § 263.002(a)(3) and (10), as well as Board Rule 108.9(6) at the same time. However, Board Rule 108.9(6) contained different language in 2009.

143 As noted earlier, Rule 108.9 in effect in 2009 does not contain language that would support a finding of a violation for this patient.

144 Tr. at 56. Dr. Watts also said that “[t]he only way to visually see that is clinically” due to the enamel overlap. Tr. at 57.

145 Tr. at 71.
specific surfaces of the tooth. When questioned about whether there is a Board rule requiring charting each specific surface of the tooth, Dr. Watts said that was his understanding because the Board required documentation of the condition of each tooth. Dr. Watts agreed that decay is not always diagnosable on an x-ray. It is diagnosed "by what you put in the chart about the clinical condition of the tooth." A clinical examination involves a check of all the surfaces to see which parts are solid and which ones are decalcified or soft or have some kind of abnormality. This is done through the use of an explorer. The explorer is held by the dentist, who runs it around all the tooth's surfaces to see if it is smooth and if it has any pitted or choppy, chalky areas that are soft. If the explorer sticks somewhere, that does not always mean there is decay; it could also mean that there is a crevice or a pit. However, it could mean that there is decay. Dr. Watts agreed that Respondent's record states that Respondent used an explorer and charted the decayed teeth.

Dr. Watts did not see decay on Tooth D on the September 22, 2011 radiograph. He noted that the patient was five years old and said that the treatments should be based on how long the tooth is going to be there. He did not believe a dentist needed to become aggressive on any anterior teeth, such as Tooth D, on a five-year-old. Several factors would need to be considered, such as how long it will be before a tooth comes out, the general decay rate in the rest of the mouth, and the previous history. When asked whether it was a good idea to restore the tooth, Dr. Watts testified that it would be only if the decay was encroaching so that you think it was going to cause detriment to that tooth and a potential abscess. If Respondent found that

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146 Tr. at 71-72; Joint Ex. 5 at 16.
147 Tr. at 73.
148 Tr. at 73.
149 Tr. at 74.
150 Tr. at 74-75.
151 Tr. at 75.
152 Tr. at 58.
153 Tr. at 58-59.
154 Tr. at 76-77.
level of decay through his clinical examination with the explorer, Dr. Watts agreed that restoration would be within the standard of care.\textsuperscript{155}

Dr. Watts testified that he did not see decay on the radiograph for Tooth G. He said he was unable to see decay present in the radiograph that would justify a restoration on this tooth and Tooth D.\textsuperscript{156} In reviewing radiographs of teeth C, D, G, and H that were taken by another dentist,\textsuperscript{157} Dr. Watts said that he was unable to see any decay on these teeth.

Further, Dr. Watts explained that a clinical exam needs to diagnose where caries is, but Respondent’s record just says “generalized areas, interproximal decay,” without explaining more detail about the rest of the teeth’s surfaces. With more explanation, a dentist can justify why sometimes a tooth needs a crown such as “when it may only be a small interproximal lesion, but you’ve got softening of the enamel 360 around the tooth.”\textsuperscript{158} Dr. Watts testified that it is overtreatment to fit a crown when it is not medically indicated.\textsuperscript{159}

Conversely, Dr. Orr testified that decay was visible on the radiographs of the teeth in question.\textsuperscript{160} He opined that if Respondent considered the radiographs and the results of his clinical examination using an explorer, Respondent’s decision to restore the teeth was within the standard of care.\textsuperscript{161} Because the patient had poor oral hygiene and was a high-risk patient, if the decay was not visible on the teeth but Respondent was able to diagnose it using the explorer, Dr. Orr testified that the teeth should have been restored.\textsuperscript{162} Dr. Orr explained that decay is often more extensive than what shows on a radiograph so the radiograph in and of itself is not

\begin{thebibliography}{99}
\bibitem{155} Tr. at 77.
\bibitem{156} Tr. at 59.
\bibitem{157} Joint Ex. 5 at 73; Tr. at 59-60.
\bibitem{158} Tr. at 64.
\bibitem{159} Tr. at 64.
\bibitem{160} Tr. at 147.
\bibitem{161} Tr. at 147.
\bibitem{162} Tr. at 148.
\end{thebibliography}
diagnostic.\footnote{Tr. at 165.} He agreed that to make a proper diagnosis, a radiograph, a clinical exam, and other findings are necessary.\footnote{Tr. at 165.}

b. \textbf{Allegation 8} (failing to comply with the minimum standard of care by failing to use protective stabilization devices and techniques in accordance with the appropriate professional standards and guidelines, resulting in injury to the patient).

After reading the treatment notes for the September 22, 2011 visit, Dr. Watts was asked whether Patient 5 was sedated.\footnote{Tr. at 61.} Dr. Watts testified that the patient was not anesthetized and he did not believe sedation was given. He observed that a papoose board is used to treat a young child who is uncooperative in order to restrain the child from hurting himself and the dentist. He said that sedation might be necessary even if a papoose board was used, depending on the procedure.\footnote{Tr. at 61-62.} Dr. Watts initially testified that he did not see in the records whether the patient’s parents were consulted about using the papoose board,\footnote{Tr. at 62.} but he later agreed that the record did reflect this information.\footnote{Tr. at 69; Joint Ex. 5 at 16, 20.} In his opinion, Respondent met the standard of care for the use of the papoose board,\footnote{Tr. at 70.} but he disputed that a papoose board was necessary. According to Dr. Watts, small fillings or minimally invasive treatment, such as that given to Patient 5, would not be considered an urgent treatment, justifying the use of a papoose board.\footnote{Tr. 63.} Dr. Watts noted that the record showed that treatment was discontinued.\footnote{Tr. at 63.}

c. \textbf{Allegation 9} (failing to comply with the minimum standard of care by failing to make and maintain adequate records because the records did not include signed, written informed consent for treatment of primary care teeth D and G).
According to Dr. Watts, the problem with Respondent’s description of his diagnosis and treatment of the patients is that the records say the same things each time, such as with a computer button. Dr. Watts said that it was not really a clinical exam, just a standardized condition listed for every tooth that needed a crown. Dr. Watts said this is “ok” if all of the things listed are true. However, Dr. Watts did not believe they were. Dr. Watts said the findings needed to be customized. While he said that the use of a template is not a problem in itself, the dentist needs to diagnose where the caries is located and the condition of the surface of the teeth, based on the dentist’s clinical examination and radiograph. He clarified that the problem with the way Respondent documented the diagnosis and treatment is that the record is not accurate about the condition of the teeth, what treatment is necessary, and the reason for the treatment. Instead, the records just document the treatment the Respondent was going to do. The diagnoses in the records were generalized, instead of specific.

With respect to the informed consent for the treatment of Teeth E and G, Dr. Orr agreed that this was not in the records. However, there was a general informed consent. Dr. Orr also agreed that the use of the papoose board was within the standard of care.

Dr. Orr agreed that a record needed to be reliable in order to be adequate. However, he testified that he did not know how the credibility of the record could be judged. He agreed that a chart entry would need to be credible to be adequate. When asked whether he should be able to see some bit of decay on a radiograph when the record states that there is decay going

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172 Tr. at 65.
173 Tr. at 64.
174 Tr. at 65.
175 Tr. at 66.
176 Tr. at 66-67.
177 Tr. at 67.
178 Tr. at 148.
179 Tr. at 149.
180 Tr. at 149.
181 Tr. 149.
182 Tr. at 149.
183 Tr. at 150.
into the pulp in the middle of the tooth, Dr. Orr said that he regularly found the opposite to be true.  

\textsuperscript{184}

\textit{d. Analysis}

The treatment of Patient 5’s primary teeth C, D, G, and H was not supported by medical necessity because the radiographs and documentation in Patient 5’s record did not show the level of decay on the teeth that would justify four surface fillings on all four of the teeth. Although Respondent’s record reflected that he used an explorer on clinical exam and charted the decayed teeth, there was no charting that stated specifically where on the individual teeth the decay was found. Further, because the patient was only five years old, several factors should have been considered before determining that all the teeth needed to be filled, such as how long it would be before the primary teeth were expected to come out, the general decay rate that existed in the rest of the mouth, and the patient’s previous history. Only if the decay was encroaching to the extent that the tooth was going to be detrimentally affected or there was the possibility of a potential abscess would there be a need for filling the decay. Respondent’s records, however, reflected caries only in generalized areas and interproximal decay without further explanation. Because the records lacked further explanation, the fillings constituted over-treatment of the primary teeth. \textsuperscript{185}

With respect to the allegation that Respondent failed to use protective stabilization devices and techniques in accordance with the appropriate professional standards and guidelines, resulting in injury to the patient, the evidence establishes that consent was provided by the patient’s mother to use a papoose restraint while the work was done. During the procedure, the patient bit down on a bite block, causing petechiae on her face due to the strain. Although Respondent terminated the treatment when this occurred, the treatment does not appear to be justified and is an example of over-diagnosis which resulted in some injury to the patient. The proposed treatment also was not urgently needed. If so, it would have justified the use of a

\textsuperscript{184} Tr. at 153.

\textsuperscript{185} Although Staff’s allegations regarding Patient 5 included an allegation that Respondent did not place the fillings on teeth C, D, G, and H but charged the patient’s insurance provider for the work, there was no evidence of this.
papoose restraint. Consequently, Respondent failed to comply with the standard of care for using the stabilization device.

With respect to Respondent’s records for this patient, there is no signed, written informed consent by the patient’s parent or guardian for the treatment to be performed, although there was consent for the use of the papoose restraint. The other problems with Respondent’s records are the same as in the prior analysis sections for the other patients.

In summary, the evidence established that Respondent violated Code § 263.002(a)(3), (4), and (10). Additionally, Respondent violated Board Rules 108.2(d) and (e), 108.7(1), (6) and 108.7(6), 108.8(c)(2)(A), and 108.8(c)(8).

E. Recommendation

Under the Matrix, a standard of care violation for practicing below the minimum standard of care with patient harm or a risk of patient harm and misleading the patient as to the gravity of their dental needs is a Second Tier Violation. The range of punishment is a warning, reprimand, probated suspension with stipulations, denial, suspension, revocation, or request for voluntary surrender. Staff requests a probated suspension. Although no evidence was offered regarding why this should be the sanction for this violation, it is within the range for the violation. Applying the aggravating factors of the Matrix, the ALJ notes that these violations were established for each of the five patients, and harm or a risk of harm occurred to the patients, including that unnecessary work was performed, a tooth that should have been extracted was retreated, and the use of a papoose restraint resulted in the patient’s developing petechiae.

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186 The ALJ notes that Code § 263.002(a)(3) refers to dishonorable conduct, a subject that is also defined in Board Rule 108.9, which states that “dishonorable conduct” includes, among other things, the violation or refusal to comply with a law relating to the regulation of dentists . . . which is identical to Code § 263.002(a)(10). So, Respondent’s failure to comply with the Board’s rule relating to documentation can essentially violate Code § 263.002(a)(3) and (10), as well as Board Rule 108.9(6) at the same time.

187 As noted earlier, Rule 108.9 in effect in 2009 does not contain language that would support a finding of a violation for this patient.

188 Code § 263.002(a)(4); Board Rules 108.2, 108.7.
For the violation of dishonorable conduct,\textsuperscript{189} which includes repeated acts of dishonorable conduct or dishonorable conduct that places a patient at risk of harm and failing to meet the duty of fair dealing in advising or treating a patient, the violations are considered Second Tier Violations. The range of punishment is a warning, reprimand, probated suspension with stipulations, denial, suspension, revocation, or request for voluntary surrender. Staff requests a probated suspension. No evidence was offered to explain why this was the appropriate sanction, but it is within the range of authorized sanctions.

For the record-keeping violations,\textsuperscript{190} Staff contends this is a First Tier Violation with the sanction of a warning. This is an available sanction under Code § 263.002(a)(4). However, Staff does not seek a warning in this case because of the more substantive other violations.

Based on the evidence, the ALJ recommends that the Board impose a five-year probated suspension against Respondent’s dental license, as requested by Staff.

### III. FINDINGS OF FACT

1. Joshua E. Foreman, DDS (Respondent) holds License Number 23918 issued by the Texas State Board of Dental Examiners (Board).

2. On October 2, 2015, staff (Staff) of the Board sent Respondent a copy of its Formal Complaint and Notice of Hearing.

3. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short plain statement of the matters asserted.

4. The hearing on the merits was convened by Administrative Law Judge Suzanne Formby Marshall on September 29, 2015, at the hearings facility of the State Office of Administrative Hearings in Austin, Texas. Staff appeared through Staff Attorney Richard Gober. Respondent appeared through attorneys Robert Anderton and Mark Hanna. The record closed after the final submission of briefs on January 8, 2016.

5. Respondent treated Patient 1, 2, 3, and 4 in July, October, and November of 2009.

\textsuperscript{189} Code § 263.002(a)(3); Board Rule 108.9.

\textsuperscript{190} Code § 263.002(a)(4), (10); Board Rule 108.8

7. Patients 1, 2, 3, 4, and 5 were minor patients who were covered by Medicaid insurance at the time of their treatment.

8. As reflected in Respondent’s records for Patient 1, on July 22, 2009, Respondent diagnosed primary teeth A, E, F, and J as having proximal caries that indicated the need for a stainless steel crown on each tooth, based on the radiographic and clinical exam Respondent performed for each tooth. However, the radiographs did not reflect the proximal caries.

9. Although Respondent’s treatment record for Patient 1’s primary teeth A, E, F, and J documented the removal of extensive occlusal and interproximal caries through the dentin, the radiographs for each tooth did not display visible interproximal caries or occlusal caries.

10. Respondent’s records for Patient 1 did not specifically discuss his observations, charting, and findings during his clinical exam of Patient 1’s primary teeth A, E, F, and J in a manner that would support his diagnosis and treatment or explain the discrepancy between the lack of visible interproximal or occlusal caries on the radiographs and his clinical examination findings.

11. Respondent seated four stainless steel crowns on primary teeth A, E, F, and J of Patient 1 without documented medical necessity for the treatment in either the radiographs or documentation of the clinical exam in Patient 1’s records.

12. Respondent’s charting in the records for Patient 1 consisted of identical notations for each tooth, without further information to distinguish the radiograph findings.

13. Respondent over-diagnosed and provided over-treatment to Patient 1.

14. Respondent’s treatment plans and diagnoses for Patients 1 through 5 were “canned” and did not accurately document the specific findings resulting from the radiographs, clinical examination, and charting.

15. On October 6, 2009, Respondent diagnosed Patient 2’s primary teeth A and B as having proximal caries that indicated the need for a stainless steel crown on each tooth, based on the radiographic and clinical examination Respondent performed for each tooth. However, the radiographs did not reflect proximal caries, and Respondent’s records do not contain information explaining his diagnosis, given the discrepancy between the radiographs and his clinical examination findings.

16. Although Respondent’s treatment record for Patient 2’s primary teeth A and B documented the removal of extensive occlusal and interproximal caries through the dentin, the radiographs for each tooth did not display visible interproximal caries or occlusal caries.
17. Respondent's records for Patient 2 did not adequately discuss his observations, charting, and findings during his clinical exam of primary teeth A and B in a manner that would support his diagnosis and treatment or explain the discrepancy between the lack of visible interproximal or occlusal caries from the radiographs and his finding that such existed after his clinical examination.

18. Respondent seated two stainless steel crowns on primary Teeth A and B of Patient 2 without documented medical necessity for the treatment in either the radiographs or specific documentation of the clinical examination's findings in Patient 2's records.

19. Respondent over-diagnosed and provided over-treatment to Patient 2.

20. On October 6, 2009, Respondent administered 3.5 carpules of 2% Lidocaine and Epinephrine to Patient 3 when the maximum dosage for this patient (based on the patient's weight) was 2.7 carpules.

21. Giving Patient 3 an excessive dose of anesthetic could have caused injury to the patient.

22. Respondent should have discontinued treatment of Patient 3 instead of increasing the anesthetic dose.

23. On that date, Respondent seated stainless steel crowns with open margins on primary teeth B, L, and S for Patient 3.

24. Respondent performed a pulpotomy on primary tooth S that was substandard due to a foreign substance extending out from the crown down the distal root of the tooth.

25. The crown on Patient 3’s primary tooth S had open margins due to the deep decay on the tooth. The root area of the tooth was also exposed.

26. Patient 3’s primary tooth S should have been extracted instead of restored.

27. On October 6, 2009, Respondent diagnosed Patient 3’s primary teeth B, L, and S as having proximal caries that indicated the need for a stainless steel crown on each tooth, based on the radiographic and clinical examination Respondent performed for each tooth. However, the radiographs did not reflect proximal caries, and Respondent’s records do not contain information explaining his diagnosis, given the discrepancy between the radiographs and his clinical examination findings.

28. Although Respondent’s treatment record for Patient 3’s primary teeth B, L, and S documented the removal of extensive occlusal and interproximal caries through the dentin, the radiographs for each tooth did not display visible interproximal caries or occlusal caries.

29. Respondent’s records for Patient 3 did not adequately discuss his observations, charting, and findings during his clinical exam of primary teeth B, L, and S in a manner that would support his diagnosis and treatment or to explain the discrepancy between the lack of
visible interproximal or occlusal caries from the radiographs with his finding that such existed after his clinical exam.

30. Respondent seated stainless steel crowns on Patient 3’s primary teeth B, L, and S without documented medical necessity for the treatment in either the radiographs or Patient 2’s records.

31. Respondent over-diagnosed and provided over-treatment to Patient 3.

32. On November 3, 2009, Respondent performed a pulpotomy and seated a stainless steel crown on Patient 4’s primary tooth T when the radiograph showed the tooth had an abscess in the furcation. The tooth should have been extracted, and a space should have been created for the permanent tooth instead of seating a crown on the tooth.

33. Tooth T had been previously treated with a pulpotomy on April 17, 2009. At that time, there was no abscess in the furcation.

34. When an abscess later developed on Patient 4’s primary tooth T, Respondent failed to diagnose it.

35. On September 22, 2011, Respondent diagnosed fillings on Patient 5’s primary teeth C, D, G, and H without medical necessity contained within the radiographs and written documentation in Patient 5’s records.

36. Respondent used a papoose to restrain Patient 5 when the required treatment was not urgently needed.

37. During the treatment of Patient 5, she developed petechiae when she bit down hard on a bite block.

38. At most, there was only a minor level of decay on the surfaces of Patient 5’s primary teeth C, D, G, and H.

39. Respondent’s records for Patient 5 do not contain a written informed consent for the treatment of Patient 5’s primary teeth D and G.

IV. CONCLUSIONS OF LAW


2. The State Office of Administrative Hearings has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law. Tex. Gov’t Code ch. 2003.
3. Notice of the complaint and of the hearing on the merits was provided as required. Tex. Gov’t. Code §§ 2001.051, .052.

4. Staff had the burden of proving the case by a preponderance of the evidence. 1 TAC § 155.427.

5. Staff proved that Respondent practiced dentistry in a manner that constituted dishonorable conduct for Patients 1-3, and 5. Tex. Occ. Code § 263.002(a)(3).


7. Staff proved that Respondent violated or refused to comply with a law relating to the regulation of dentists for Patients 1-3, 5. Code § 263.002(a)(10).

8. Staff proved that Respondent misled dental patients 1-5 as to the gravity or lack thereof of such dental patient’s needs. 22 Tex. Admin. Code § 108.2(d).

9. Staff proved that Respondent persistently overdiagnosed and overtreated Patients 1-5. 22 Tex. Admin. Code § 108.2(e).

V. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the Board should issue a five-year probated suspension of Respondent’s dental license.

SIGNED March 8, 2016.

[Signature]
SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS