BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In the Matter of SHAWANA NEOPI PATTERSON, D.D.S. (License No. 9248)	)))))	**NOTICE OF HEARING**

TO: SHAWANA NEOPI PATTERSON, D.D.S,.
c/o Elizabeth F. Greene
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Flannery Georgalis, PLLC
227 West Trade Street
Suite 950
Charlotte, NC 28202

TAKE NOTICE that on April 18, 2024 at 6:30 p.m., or as soon thereafter as it can be heard, the North Carolina State Board of Dental Examiners ["the Board"], pursuant to G.S. §§ 90-41.1, 90-42, and 150B-38, and the Board's Rules and Regulations, 21 N.C.A.C. 16N .0504, will conduct a hearing at the offices of the North Carolina State Board of Dental Examiners located at 2000 Perimeter Park Drive #160, Morrisville, North Carolina. The hearing will continue from day to day until completed. The hearing is to determine whether the Board, in its discretion, should grant the petition of Shawana Neopi Patterson, D.D.S. ["Petitioner" or "Dr. Patterson"] for reinstatement of her North Carolina dental license upon a satisfactory evidence of proper reformation after a hearing. The specific factual allegations in this matter are:

NOTICE OF FACTUAL ALLEGATIONS

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act in Article 2

and the Rules and Regulations of the Board set forth in 21 North Carolina Administrative Code Chapter 16.

2. On October 21, 2011, Petitioner was issued license number 9248 to practice dentistry by credentials in North Carolina.

3. Prior to January 11, 2019, Petitioner worked as an oral and maxillofacial surgeon in High Point, North Carolina, subject to the Dental Practice Act and the rules promulgated thereunder.

4. On June 27, 2018, the Board issued a Notice of Hearing to Petitioner following the deaths of two of Petitioner's patients to whom she administered anesthesia, charging her with negligence and malpractice in the practice of dentistry, as well as violation of the Board's sedation rules.

5. On November 8-10, 2018, the Board held a formal hearing on the matters alleged in the June 27, 2018, Notice of Hearing.

6. On January 11, 2019, the Board issued a Final Agency Decision revoking Petitioner's North Carolina dental license and anesthesia permit and making the following findings and conclusions:

Treatment of Patient RG

a. On November 9, 2017, Petitioner performed non-emergency oral surgery on and administered anesthesia to Patient RG. RG had a significant health history that included high blood pressure, heart attack, cardiac pacemaker/defibrillator, bronchitis/chronic cough, diabetes, and swollen ankles/arthritis/joint disease. Despite all indications that RG was not a candidate for general anesthesia outside of a hospital setting, Petitioner

proceeded to administer anesthesia to RG without obtaining a medical clearance or otherwise consulting with any of RG's physicians. Petitioner also failed to obtain RG's blood glucose level before administering anesthesia and beginning the surgical procedure.

b. Petitioner proceeded to over-sedate RG with 50 mcg of fentanyl, 10 mg of midazolam, 100 mg of propofol, 4 mg of dexamathasone, and 45 mg of Marcaine. RG's blood pressure dropped to a level inadequate to perfuse sufficient blood and oxygen to a patient's vital organs, including the brain, but Petitioner continued to administer additional anesthesia and perform surgery. Petitioner's oral surgery assistant testified that early into the administration of anesthesia, she advised Petitioner that RG was turning bluish-gray, but Petitioner dismissed her concern and proceeded with the surgery.

c. Following the surgery, RG became diaphoretic and remained unresponsive, and Emergency Medical Services was contacted. Petitioner never used an automated external defibrillator (AED) on or administered epinephrine to RG, nor did she check RG's blood glucose post-operatively.

d. Emergency workers arrived at Petitioner's office and found RG unresponsive with an oxygen saturation level of 55%, blood glucose level of 547, and only 2 liters of oxygen were being administered to RG by Petitioner. RG was transported to the hospital, where he was intubated and admitted to the intensive care unit (ICU).

e. Physicians subsequently determined that RG suffered:

i. Cerebellar stroke or cerebrovascular accident;

ii. Brainstem stroke syndrome;

iii. Hypoxic-ischemic encephalopathy; and

iv. Quadriparesis.

f. RG's diagnoses were consistent with anoxic brain damage from a deprivation of oxygen. After several months of attempted rehabilitation, RG died on February 11, 2018.

g. Several experts and RG's treating physician testified at the hearing. The collective expert testimony indicated that Petitioner breached the standard of care in her treatment of RG, including her pre-operative assessment, interoperative management, and oversedation of RG, and that the breach caused RG's anoxic brain injury, his cerebellar stroke or cerebrovascular accident, and his ultimate death. The Hearing Panel found the experts' testimony to be credible.

h. Two of Petitioner's former employees testified that RG's treatment record had been falsified. The Hearing Panel found the former employees' testimony credible and Petitioner's contrary testimony on this issue not credible.

Treatment of Patient DM

i. On March 28, 2018, a matter of months after the incident with RG, Patient DM presented to Petitioner's office for a non-emergency procedure under anesthesia. Before the procedure, DM disclosed a health history including kidney trouble – on dialysis, diabetes, swollen ankles, arthritis or joint

disease, high blood pressure, and anemia. DM also had a visible dialysis catheter or fistula in her arm, the presence of which indicated that DM had end-stage renal disease and would have been confirmed had Petitioner investigated DM's suitability for anesthesia. Despite DM's health history, Petitioner did not contact or consult with, request medical clearance, or obtain medical records from DM's physician prior to administering anesthesia or performing surgery. DM was an inappropriate candidate for anything but an emergency surgical procedure and was an inappropriate candidate for administration of any anesthesia outside of a hospital setting.

j. Directly before the procedure, DM's blood pressure was 187/115, which indicated she was in hypertensive crisis. DM's first blood oxygen concentration was recorded in the 80s, and even before anesthesia was administered, DM's blood oxygen concentration had dropped to the 70s. Petitioner did not obtain DM's blood glucose level pre-operatively, despite being aware that she was a diabetic.

k. Despite all of the contraindications, Petitioner proceeded to over-sedate DM with 50 mcg Fentanyl, 5 mg midazolam, 60 mg propofol, and 4 mg dexamethasone. Petitioner's administration of the combination of these drugs to DM was excessive. Following administration of sedation, the vital signs recorded and the data from Petitioner's monitors showed that DM was deteriorating into respiratory and cardiac arrest.

l. Once Petitioner recognized the danger, she attempted reversal of sedation and basic life support, but did not administer advanced cardiac life support

protocols, use an AED, or administer epinephrine. Petitioner's office contacted EMS after she determined that DM had no pulse.

m. EMS responded, recovered DM's pulse, and transported DM to the hospital, but the pulse was lost several more times. It was determined that DM was without a pulse or spontaneous circulation for at least forty minutes total. The hospital staff diagnosed her with anoxic encephalopathy secondary to cardiac arrest. While in intensive care at the hospital, awaiting a second consultation to confirm loss of brain function, DM went into cardiac arrest and died on April 1, 2018, several days after Petition administered anesthesia.

n. Expert witnesses and DM's treating physician testified at the hearing. Collectively, the experts and treating physician testified that Petitioner violated the standard of care in her assessment, treatment, and monitoring of DM, causing or contributing to DM's cardiac arrest and her subsequent death. The Hearing Panel found the experts' testimony to be credible.

o. Petitioner did not make any changes in her office after RG's emergency situation on November 9, 2017 and before DM's subsequent emergency situation and her subsequent death on April 1, 2018.

7. Based on the foregoing findings, the Hearing Panel concluded that:

a. Petitioner violated the applicable standard of care for dentists practicing in North Carolina in her assessment, treatment, and monitoring of Patient RG on November 9, 2017, and such violation caused or contributed to RG's stroke and anoxic brain injury and RG's eventual death from a stroke; the

Hearing Panel further concluded that Petitioner violated N.C. Gen. Stat. § 90-41(a)(6)(12),(19), and 21 NCAC 16Q .0202 in her treatment and care of RG.

b. Petitioner violated the applicable standard of care for dentists practicing in North Carolina in her assessment, treatment, and monitoring of Patient DM on March 28, 2018, and such violation contributed to DM's cardiac arrest and subsequent death from cardiac arrest; the Hearing Panel further concluded that Petitioner violated N.C. Gen. Stat. § 90-41(a)(6)(12),(19), and 21 NCAC 16Q .0202 in her treatment and care of DM.

8. In reaching the decision to revoke Petitioner's North Carolina dental license, the Hearing Panel also determined that:

a. Petitioner's numerous and compounded acts of negligence and malpractice were not caused by and did not result from a lack of training or inadequate training in these practice areas and, consequently, additional education and training could not remediate her violations.

b. Petitioner failed to demonstrate genuine remorse or accept full responsibility for her violations and other misconduct. Rather, Petitioner consistently attempted to place blame for her actions on others, including on Patients RG and DM, despite her disingenuous assertions to the contrary in her testimony.

c. Petitioner fabricated or directed her employee(s) to fabricate her patient treatment records in an effort to conceal her violations and avoid responsibility for them.

d. Petitioner acted carelessly and in reckless disregard for the safety and well-being of her patients, and Petitioner's testimony on this issue was not credible.

e. Petitioner made no meaningful changes in her patient assessment, administration of anesthesia, or monitoring of patients between her treatment and standard of care violations concerning RG on November 9, 2017 and her treatment and standard of care violations concerning DM on March 28, 2018, demonstrating a carelessness or reckless disregard for the safety and well-being of her patients.

f. Petitioner posed such a grave risk to the public in administering general anesthetics or sedation that she should be disqualified permanently from holding a general anesthesia permit or any level of sedation permit and prohibited from administering any level of sedation in North Carolina.

g. Petitioner's numerous, compounded violations and other conduct, including her actions taken carelessly and in reckless disregard for the safety and well-being of her patients, demonstrated that she poses a significant risk to the public extending beyond administration of general anesthesia and sedation to any aspect of her dental treatment for patients.

h. If Petitioner were permitted to continue practicing dentistry, even without providing general anesthesia and sedation, there is a significant risk that she will engage in further misconduct and pose a significant risk to the public safety and well-being.

i. Petitioner's misconduct involved such serious, numerous violations of the Dental Practice Act that revocation of her dental license and anesthesia permit was the only discipline or disciplinary measure sufficient to protect the public.

j. Petitioner's numerous violations and the other misconduct set forth herein would require substantial and lengthy reformation, even assuming such rehabilitation is possible, before she potentially could be considered eligible for reinstatement of a dental license in the future. Therefore, Petitioner was not able to be considered for reinstatement of her dental license for at least three years from the date of the January 11, 2019 Final Agency Decision.

9. In February 2022, Petitioner submitted an application for reinstatement of her North Carolina dental license. Upon receiving the application, the Investigative Panel for the Board reopened and investigated several complaints that were pending at the time of Petitioner's revocation. After completing its investigation of those matters, the Investigative Panel determined that Petitioner's first application for reinstatement did not satisfy the necessary requirements, including failing to demonstrate reformation. The Investigative Panel issued a letter on June 1, 2023 notifying Petitioner about the denial of her application for reinstatement and of her right to request a formal hearing before the full Board within 30 days. Petitioner did not submit a request for a hearing on her first application and the matter was closed.

10. In October 2023, Petitioner submitted her second application for reinstatement. The Investigative Panel reviewed this second reinstatement application and determined that Petitioner had not substantiated the requirements for reinstatement,

including demonstrating reformation. The Investigative Panel issued a letter on November 9, 2023, notifying Petitioner of the denial of her second application and that she could request a hearing on the denial. Through counsel, Petitioner timely requested a hearing on the denial of her second application for reinstatement. On December 8, 2023, the Hearing Panel for this matter in its discretion granted Petitioner's request for a hearing.

NOTICE OF PROCEDURAL MATTERS

At the formal hearing of this case, you will be given an opportunity to appear and be heard in person, to confront the witnesses appearing for the Board, to cross-examine them, and to offer evidence in support of your petition as you see fit. As Petitioner, you have the burden of establishing that you have reformed since your revocation, possess good moral character, and can safely resume the practice of dentistry.

You are entitled to be represented by counsel at the hearing or you may appear on your own behalf without counsel. Continuances will be granted only for good cause. Failure to retain counsel will not be considered as a basis to grant a continuance on the day of the hearing.

This the 4th day of January, 2024.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

BY: Jamie L Rivera
Jamie L. Rivera
On behalf of and at the Direction of the
Investigative Panel