

BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:)
)
) **FINAL AGENCY DECISION**
SHAWANA NEOPI PATTERSON, D.D.S.)
(License No. 9248))
)

THIS MATTER was heard before the North Carolina State Board of Dental Examiners ["Board"] on November 8-10, 2018, pursuant to N.C. General Statute §§ 90-41.1 and 150B-38 and 21 NCAC 16N .0504 of the Board's Rules. The Board's Hearing Panel consisted of Board members Dr. Millard W. Wester, III, presiding, Dr. Merlin W. Young, Dr. William M. Litaker, Jr., and Dr. Edward J. Clemons. Board members Dr. Kenneth M. Sadler, Dr. Catherine A. Watkins, Ms. Nancy A. St. Onge, and Mr. Dominic Totman did not participate in the hearing, deliberation, or decision of this matter. Charles George, Dhamian A. Blue, and Daniel T. Blue, Jr. represented Respondent, Dr. Shawana Neopi Patterson ["Respondent"]. Douglas J. Brocker and Crystal S. Carlisle represented the Investigative Panel, and Fred Morelock represented the Hearing Panel.

Based upon the stipulations of the parties and the evidence introduced at the hearing, the Board Hearing Panel makes the following:

FINDINGS OF FACT

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. Respondent was licensed to practice dentistry by credentials in North Carolina on October 21, 2011 and has held license number 9248 at all times relevant hereto.

3. Respondent has remained licensed to practice dentistry in North Carolina and was subject to the Dental Practice Act and the Board's Rules and Regulations at all times relevant hereto.

4. At all times relevant hereto, Respondent worked as an oral and maxillofacial surgeon in High Point, North Carolina in her dental practice, Patterson Oral & Maxillofacial Surgery.

5. Respondent was properly served with the pleadings in this matter and had appropriate and adequate notice of the hearing dates.

Respondent's Treatment of Patient RG

6. On November 9, 2017, Patient RG presented to Respondent's office for alveoloplasty of four quadrants after a full mouth extraction by another provider.

7. Before the procedure at a separate consultation appointment on September 5, 2017, RG completed a health history form indicating yes for the following conditions: high blood pressure, heart attack, cardiac pacemaker/defibrillator, bronchitis/chronic cough, diabetes, and swollen ankles/arthritis/joint disease.

8. By her own admission, Respondent did not request medical clearance or medical records from or attempt to contact or consult with RG's primary care physician (PCP) or any specialist physician pre-operatively between September 5 and November 9, 2017.

9. RG's PCP possessed additional health information, including about the conditions disclosed in his health history, demonstrating that RG 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.

10. By her own admission, Respondent did not obtain RG's blood-glucose level before administering anesthesia and beginning the surgical procedure on November 9, 2017.

11. Respondent performed RG's procedure in her dental office using general anesthesia, despite the information provided by RG and her failure to obtain critical information and available data demonstrating that RG was an inappropriate candidate for this non-emergency surgery and administration of anesthesia in her dental office.
12. Respondent did not have an assistant continuously present during RG's procedure that was dedicated to patient monitoring or recording general anesthesia or sedation data throughout the procedure.
13. The anesthetic Respondent used in RG's procedure included 50 mcg Fentanyl, 10 mg midazolam, 100 mg propofol, 4 mg dexamethasone, and 45 mg Marcaine.
14. The anesthetic Respondent used in RG's procedure was excessive and caused him to be oversedated.
15. Early into the administration of anesthesia, RG's blood pressure dropped from 122/60 to blood pressures inadequate to perfuse sufficient blood and oxygen to a patient's vital organs, including the brain.
16. Respondent continued to administer additional anesthesia and perform surgery after RG's blood pressures dropped to levels inadequate to perfuse blood and oxygen to his vital organs, including his brain.
17. Respondent took no action to attempt to raise RG's blood pressure to a perfusing state.
18. RG's dangerously low blood pressures existed for an extended period of time during and after Respondent's surgery.
19. Respondent's oral surgery assistant testified that early into the administration of anesthesia, she advised Respondent that RG was turning bluish-gray, and Respondent dismissed her concern and proceeded with the surgery.
20. Based on the assistant's testimony and the testimony of multiple other witnesses indicating RG was ashen, gray, or blue at later times, the assistant's testimony was credible and Respondent's contrary testimony on this issue was not credible.
21. Approximately 2½ hours after first administering anesthesia and the beginning of the procedure, and approximately 1½ hours after the end of the surgery,

according to Respondent's treatment record, RG became diaphoretic and remained unresponsive and Emergency Medical Services (EMS) was contacted.

22. Testimony from witnesses, as well as an examination of Dr. Patterson's records, demonstrated that an EKG was not used on RG Intra-operatively or post-operatively. Respondent's contrary testimony was not credible.

23. By her own admission, Respondent never used an automated external defibrillator (AED) on or administered epinephrine to RG.

24. Respondent admittedly did not check RG's blood glucose post-operatively, including when he did not recover from the anesthetics.

25. Respondent's records indicate that she did administer reversal drugs later in post-operative care. However, according to Respondent's expert witness, Dr. Fonseca, RG probably was already "beyond the point of no return" based on the excessive dose of anesthesia medication she had administered to RG.

26. High Point Fire Department found RG unresponsive upon arrival with an oxygen saturation level of 55%, blood glucose level of 547, and only 2 liters of oxygen were being administered to RG by Respondent.

27. An oxygen saturation level of 55% was well below the level sufficient to perfuse RG's organs and would have been inadequate even for a healthy patient.

28. Guilford County EMS personnel assessed RG as a 3 on the Glasgow Coma Scale (GCS), the lowest value on the scale.

29. EMS transported RG to High Point Regional Health (HPRH), and he remained unresponsive upon arrival at approximately 4:28 p.m.

30. RG's blood glucose level remained severely elevated upon admission to HPRH ED, and his GCS remained at 3.

31. RG was intubated and admitted to the intensive care unit (ICU) at HPRH with concern for anoxic brain injury.

32. Physicians at HPRH subsequently determined that RG suffered:

- a. Cerebellar stroke or cerebrovascular accident;
- b. Brainstem stroke syndrome;
- c. Hypoxic-ischemic encephalopathy; and
- d. Quadriplegia.

33. RG's diagnoses at HPRH are consistent with anoxic brain damage from a deprivation of oxygen.

34. RG was discharged to the Sticht Center at Baptist Hospital for attempted rehabilitation on November 16, 2017.

35. RG died on February 11, 2018, approximately three months after the date of Respondent's anesthesia and surgery, November 9, 2017.

36. Dr. Fisher, one of RG's treating physicians at HPRH, testified to a reasonable degree of medical certainty that Respondent's treatment of RG on November 9, 2017 in her dental office, including the sedation medication she administered to RG, caused or contributed to:

- a. the conditions resulting in his admission to the emergency room at HPRH, including anoxic brain injury;
- b. his cerebellar stroke or cerebrovascular accident; and
- c. his ultimate death on February 11, 2018.

37. Dr. Fisher's testimony on these issues was credible, including satisfying the requirements of North Carolina Rule of Evidence 702 [hereafter, "compliant with Rule 702"].

38. The Investigative Panel also presented the testimony of Dr. Dillon Atwood, D.D.S., and his related written report and affidavit, concerning Respondent's treatment of RG. Dr. Atwood testified and presented evidence that Respondent's assessment, treatment, and monitoring of RG violated the standard of care and caused or contributed to his ischemic brain stem stroke or anoxic brain injury. Dr. Atwood's testimony on these issues was credible and compliant with Rule 702.

39. The Investigative Panel also presented the testimony of practicing oral and maxillofacial surgeon Dr. K. Kevin Neshat, D.D.S., and his related written report and affidavit, concerning Respondent's treatment of RG. Dr. Neshat testified and presented evidence that Respondent's assessment, treatment, and monitoring of RG violated the standard of care, and Respondent's administration of anesthesia to RG was careless and dangerous. Dr. Neshat's testimony on these issues was credible and compliant with Rule 702.

40. The Investigative Panel presented evidence that two of Respondent's former employees had knowledge that RG's treatment record had been falsified. These witnesses' testimony was credible considering: (a) documentary evidence, including comparison of Respondent's records and the High Point Fire Department records; and (b) expert witness testimony regarding RG's hypoxic state. Respondent's contrary testimony on this issue was not credible.

41. Respondent presented the expert testimony of Dr. Raymond Fonseca, D.D.S. Dr. Fonseca testified that Respondent's: (a) preanesthetic evaluation or assessment of RG violated and was below the standard of care; (b) intraoperative management of RG, including administering an excessive amount of anesthesia drugs to RG, deviated from the standard of care; and (c) oversedation of RG resulted in under perfusion and caused or contributed to his anoxic brain damage. Dr. Fonseca's testimony on these issues and in paragraph 25 was credible and compliant with Rule 702.

Respondent's Treatment of Patient DM

42. On March 28, 2018, patient DM presented to Respondent's office for extraction of multiple teeth under anesthesia, which was not an emergency procedure.

43. Before the procedure, DM completed a health history form indicating yes for the following conditions: kidney trouble – on dialysis, diabetes, swollen ankles, arthritis or joint disease, high blood pressure, and anemia.

44. DM also had a visible dialysis catheter or fistula in her arm, the presence of which indicates that DM had end stage renal disease (ESRD).

45. The information disclosed to or available to Respondent created an obligation for Respondent to consult with or get clearance from the physician treating DM's ESRD and other conditions before proceeding with anesthesia and surgery.

46. Respondent did not contact or consult with, or request medical clearance, or obtain medical records from DM's PCP or any specialist physician prior to administering anesthesia or performing surgery for DM's non-emergency procedure on March 28, 2018.

47. Hospital records from DM's admission in January 2018 contained additional health information, including about the conditions disclosed in her health history, and

demonstrated that DM had acute respiratory failure with hypoxia, pneumonia, pulmonary edema, uncontrolled hypertension, uncontrolled diabetes, ESRD, and anemia from chronic kidney failure.

48. These recent hospital records, which Respondent did not request or obtain prior to her sedation and surgical procedure on March 28, 2018, confirmed that 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.

49. Respondent's records for DM demonstrate that prior to administering anesthesia or performing surgery, DM's blood pressure was 187/115, which indicated she was in hypertensive crisis.

50. There was no evidence in Respondent's treatment record that any other blood pressure readings were taken by another device on that date. Respondent's testimony that she took blood pressure readings on a portable monitor, which alleged readings were not recorded anywhere in her records, was not credible.

51. On Respondent's operative report, DM's first blood oxygen concentration was recorded as 88%.

52. In the same operative report, before Respondent administered any anesthetics to her, DM's blood oxygen concentration had dropped to 73%.

53. On a separate operative report produced with Respondent's records for DM entitled "Readings on portable O2 device," DM's oxygen concentrations fell to 87% before any general anesthesia was administered and fell even lower to 78% before Respondent began the surgical procedure, even assuming it was a valid, contemporaneous record.

54. The vital signs recorded on both operative reports prior to the procedure were characteristic of a poorly controlled and fragile patient who was not appropriate for administration of anesthesia, particularly in an office-based setting.

55. Respondent did not obtain DM's blood-glucose level pre-operatively, despite being aware that she was a diabetic.

56. Respondent performed DM's procedure in her dental office using general anesthesia, disregarding contemporaneous data demonstrating that doing so was contraindicated and potentially very dangerous.

57. Respondent proceeded with administering anesthesia to and performing surgery on DM on March 28, 2018 despite these patent contraindications and the absence of other critical information.

58. The anesthetic Respondent used in DM's procedure included 50 mcg Fentanyl, 5 mg midazolam, 60 mg propofol, and 4 mg dexamethasone, according to her anesthesia record.

59. Respondent's administration of the combination of these drugs to DM was excessive.

60. According to Respondent's records and the data from Respondent's monitors:

- a. DM's blood pressure rose to 219/152 after Respondent administered anesthesia to her initially;
- b. Over the next fifteen minutes, after rising to 219/152, DM's blood pressure dropped to 82/65 and then 52/36; and
- c. During the procedure, DM's heart rate rose to 207; and her blood oxygen concentration never rose above 80 and even fell to 60, 59 and ultimately 37.

61. The vital signs recorded and the data from Respondent's monitors are consistent with a severely compromised patient deteriorating into respiratory and cardiac arrest that resulted in a non-perfusing blood pressure where oxygen is denied to the patient's vital tissues and organs.

62. Evidence presented at the hearing demonstrated that an EKG was not used on DM during the procedure. Respondent's contrary testimony was not credible.

63. Respondent did not have a trained and qualified assistant continuously present during DM's procedure that was dedicated to patient monitoring or recording general anesthesia or sedation data throughout the procedure.

64. When Respondent eventually recognized DM's deteriorating vital signs, shallow breathing, and motionless diaphragm, she used basic life support measures and administered reversal agents but no advanced cardiac life support protocols.

65. Respondent never used an AED on or administered epinephrine to DM on March 28, 2018.

66. According to the testimony of Respondent's expert witness, Dr. Fonseca, by that time she administered reversal drugs to DM, it was probably too late because reversal agents cannot correct cardiac arrest.
67. Respondent's office contacted EMS at approximately 4:00 p.m. after she determined that DM had no pulse.
68. Guilford County EMS assessed DM at approximately 4:14 p.m. and noted DM was unresponsive and apneic.
69. Upon arrival at Respondent's office, Guilford County EMS determined that DM was in asystole.
70. EMS personnel assessed DM as a 3 on the Glasgow Coma Scale (GCS), the lowest on the scale.
71. After utilizing ACLS protocols, EMS was able to obtain a pulse for DM at 4:33 p.m. but lost her pulse again at 4:50 p.m. while leaving Respondent's office and traveling to the HPRH. EMS was able to obtain a pulse again for DM at 5:00 p.m., right before arriving at the ED.
72. At Dr. Patterson's office and before reaching the ED, DM was without a pulse and did not have spontaneous circulation for at least forty (40) minutes total.
73. DM lost a pulse while in the ED on multiple occasions, was noted to be a critical care patient at HPRH and was intubated and placed on a ventilator.
74. Metabolic testing at HPRH indicated a poorly controlled diabetic patient in kidney failure with recent cardiac arrest.
75. DM was admitted to the intensive care unit at HPRH.
76. HPRH staff determined that DM was critically ill and diagnosed her with anoxic encephalopathy secondary to cardiac arrest.
77. While in intensive care at HPRH awaiting a second consultation to confirm loss of brain function, DM went into cardiac arrest and died on April 1, 2018.
78. Dr. Woody, one of DM's treating physicians at HPRH, testified to a reasonable degree of medical certainty that Respondent's treatment of DM on March 28, 2018 in her dental office caused or contributed to, and was likely the proximate cause of, DM's death from cardiac arrest. Dr. Woody's testimony on these issues was credible and compliant with Rule 702.

79. The Investigative Panel also presented the testimony, and related written report of Dr. Dillon Atwood, D.D.S., concerning Respondent's treatment of DM. Dr. Atwood testified and presented evidence that Respondent's assessment, treatment, and monitoring of DM on March 28, 2018 violated the standard of care and caused or contributed to her cardiac arrest and her subsequent death on April 1, 2018. Dr. Atwood's testimony on these issues was credible and compliant with Rule 702.

80. The Investigative Panel also presented the testimony of Dr. K. Kevin Neshat D.D.S., and his related written report and affidavit, concerning Respondent's treatment of DM. Dr. Neshat testified and presented evidence that Respondent's assessment, treatment, and monitoring of DM violated the standard of care. Dr. Neshat's testimony on these issues was credible and compliant with Rule 702.

81. Respondent 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.

82. Respondent presented the expert testimony of Dr. Raymond Fonseca, D.D.S. Dr. Fonseca testified that Respondent's preoperative and intraoperative management of DM deviated from the standard of care.

83. For example, Dr. Fonseca testified that Dr. Patterson's failure to do a blood glucose test on the date of surgery for DM violated the standard of care concerning preanesthetic evaluation.

84. Dr. Fonseca further testified that Dr. Patterson administered excessive amounts of anesthetics to DM on March 28, 2018 in violation of the standard of care.

85. Dr. Fonseca testified that DM already was in respiratory failure and that Dr. Patterson's administration of excessive amounts of sedation put her into respiratory depression or obstruction.

86. Dr. Fonseca's testimony on the issues in paragraphs 66 and 82-85 was credible and compliant with Rule 702.

Based on the above findings and the evidence presented in the record, the Board Hearing Panel reaches the following:

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and over the subject matter of this case.
2. Respondent 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.
3. Respondent's violation of the standard of care in her treatment and care of patient RG caused or contributed to RG's stroke and anoxic brain injury and RG's eventual death from a stroke.
4. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen. Stat. § 90-41(a)(6) and 21 NCAC 16Q .0202 in her treatment and care of RG on November 9, 2017, as set forth in Conclusions of Law 2 and 3 and Findings of Fact 6-41.
5. Respondent 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.
6. Respondent's violation of the standard of care in her treatment and care of patient DM caused or contributed to DM's cardiac arrest and subsequent death from cardiac arrest.
7. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen. Stat. § 90-41(a)(6) and 21 NCAC 16Q .0202 in her treatment and care of DM on March 28, 2018, as set forth in Conclusions of Law 5 and 6 and Findings of Fact 42-86.

In addition to the foregoing Findings of Fact and Conclusions of Law and based on the evidence presented in the record, the Hearing Panel makes the following findings and conclusions regarding mitigating and aggravating factors relevant to the appropriate discipline to impose:

ADDITIONAL FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE

1. Respondent has not been previously disciplined by the Board since obtaining her North Carolina dental license in 2011.

2. Respondent's treatment and violations of the standard of care caused or contributed to a serious medical emergency, stroke, and the eventual death of patient RG.

3. Respondent's numerous and compounded acts of negligence and malpractice that caused or contributed to RG's serious medical emergency, stroke, and eventual death independently warrant revocation of her dental license and general anesthesia permit to protect the public, even without any evidence, findings, and conclusions concerning her treatment of patient DM or without the other findings and conclusions set forth in this section.

4. Respondent's treatment and violations of the standard of care caused or contributed to a serious medical emergency, respiratory and cardiac arrest, and the eventual death of patient DM, less than five months after RG's treatment and medical emergency.

5. Respondent's numerous and compounded acts of negligence and malpractice that caused or contributed to DM's serious medical emergency, respiratory and cardiac arrest, and death independently warrant revocation of Respondent's dental license and general anesthesia permit to protect the public, even without any evidence, findings, and conclusions concerning her treatment of patient RG or without the other findings and conclusions set forth in this section.

6. Respondent'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 cannot remediate her violations.

7. Respondent failed to demonstrate genuine remorse or accept full responsibility for her violations and other misconduct. Rather, Respondent 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. Respondent's stipulations to standard of care violations reflected the expected evidence and testimony, including of her own expert witness, rather than demonstrating acceptance of responsibility or remorse.

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

9. Respondent acted carelessly and in reckless disregard for the safety and well-being of her patients by failing to have a qualified assistant in the operatory dedicated to patient monitoring and recording general anesthesia data throughout the sedation procedure in violation of 21 NCAC 16Q .0202(a)(6):

- a. during the sedation procedure and surgery on RG on November 9, 2017, which caused or contributed to RG's medical emergency;
- b. during the sedation procedure and surgery on DM on March 28, 2018, which caused or contributed to DM's medical emergency; and
- c. for other patients on a regular basis in at least 2017.

10. Respondent's hearing testimony was not credible regarding the presence of a qualified assistant in the operatory dedicated to patient monitoring and recording general anesthesia data throughout sedation procedures, including for patients RG and DM, particularly in light of her own contradictory testimony and the testimony of other witnesses on this issue.

11. Respondent acted carelessly and in reckless disregard for the safety and well-being of her patients by failing to use an EKG monitor on patients in violation of the standard of care in North Carolina including:

- a. during the sedation procedure and surgery on RG on November 9, 2017;
- b. during the sedation procedure and surgery on DM on March 28, 2018, which caused or contributed to DM's medical emergency; and
- c. on other patients on a regular basis in at least 2017.

12. Respondent's testimony was not credible concerning her use of an EKG monitor on patients, including RG and DM, particularly considering the contradictory testimony presented.

13. Respondent acted carelessly and in reckless disregard for the safety and well-being of her patients by ignoring alarms on her vitals monitor including:

- a. during and after the sedation procedure and surgery on RG on November 9, 2017, which caused or contributed to DM's medical emergency; and
- b. during the sedation procedure and surgery on DM on March 28, 2018, which caused or contributed to DM's medical emergency.

14. Respondent 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. Respondent's failure to make any meaningful changes in her assessment and treatment procedures after RG's medical emergency, hospitalization, and eventual death and before DM's medical emergency, hospitalization, and subsequent death demonstrates a carelessness or reckless disregard for the safety and well-being of her patients.

15. Respondent poses 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.

16. Respondent'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, demonstrates 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.

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

18. The Hearing Panel members are practicing general dentists and therefore expert testimony, pursuant to North Carolina Rule of Evidence 702, was unnecessary to assist in deciding the issue of Respondent's ability to practice general dentistry safely without providing anesthesia or sedation.

19. In addition to not being necessary, the testimony of Respondent's expert witness, Dr. Fonseca, on the issue of Respondent's ability to practice safely without anesthesia or sedation was based on insufficient facts or data to form or produce reliable opinions and consequently was not credible or persuasive on that issue.

20. Unlike the Hearing Panel, Dr. Fonseca did not hear all the testimony and other evidence presented at the hearing in this matter and was not present to assess or determine the credibility of those witnesses and evidence.

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

22. Respondent'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. Consequently, Respondent should not be considered for potential reinstatement of her dental license for a minimum of three years from the effective date of this Final Agency Decision.

Based on the foregoing Findings of Fact, Conclusions of Law, and Additional Findings and Conclusions Regarding Discipline, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

Respondent's license to practice dentistry in North Carolina is REVOKED. Respondent's general anesthesia permit also is REVOKED. The revocation of Respondent's license to practice dentistry and of her general anesthesia permit are both effective upon service of this Final Agency Decision. Respondent shall immediately surrender her permit, license, and current renewal certificate to the Board upon service of this Final Agency Decision.

This the 11th day of January 2019.



Dr. Millard W. Wester, Presiding Officer
on behalf of the Hearing Panel
The N.C. State Board of Dental Examiners

