BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:

Naureen Omido Ridge, D.D.S.	)	
(License No. 9953)	)	FINAL AGENCY DECISION
	)	

THIS MATTER was heard before the North Carolina State Board of Dental Examiners (Board) Hearing Panel on December 8, 2017 pursuant to N.C. Gen. Stat. §§ 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. William M. Litaker, Jr., Dr. Clifford O. Feingold, and Dr. Catherine A. Watkins. Board members Dr. Merlin W. Young, Dr. Kenneth M. Sadler, Ms. Nancy A. St. Onge, and Mr. Dominic Totman did not participate in the hearing, deliberation, or decision of this matter. Bob Crawford represented Respondent, Dr. Naureen Ridge. Doug Brocker represented the Investigative Panel of the North Carolina State Board of Dental Examiners. Fred Morelock represented the Board Hearing Panel.

Based upon the stipulations of the parties and the evidence produced at the hearing, the Board Hearing Panel enters 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 under the authority granted it in Chapter 90 of the North Carolina General Statutes (the Dental Practice Act) and the Rules and Regulations of the Board.

2. Respondent was licensed to practice dentistry in North Carolina on March 6, 2015 and has held license number 9953 at all times relevant hereto.

3. Respondent is subject to the Dental Practice Act and the Rules promulgated thereunder.

4. At all times relevant hereto, Respondent worked as a general dentist at the Rural Health Group (RHG) with offices in Roanoke Rapids and Jackson, North Carolina.

5. On August 1, 2016, patient GG presented to RHG's office for a toothache in the upper right quadrant. At that appointment, another dentist practicing at RHG, Dr. Rose Gonzales-Mugaburu conducted an examination, took radiographs, and prepared a treatment plan but performed no treatment.

6. The treatment plan Dr. Gonzales-Mugaburu prepared on August 1 included recommended restorations on various teeth, including for tooth number 3 on the distal and occiusai surfaces.

7. During that initial, August 1, 2016 appointment, Dr. Gonzales-Mugaburu diagnosed tooth number 2 as positive to percussion and touch with a large carious lesion that extended into the nerve and possibly the periapical, with pathology present. Tooth number 2 was recommended for extraction at the next visit and was the only tooth treatment planned for extraction at that initial appointment. An antibiotic also was prescribed for Patient GG at the August 1, 2016 appointment.

8. On August 4, 2016, three days after the initial appointment, patient GG return for his next visit and was treated by Respondent.

9. Respondent's treatment notes on that day indicate the following pertinent provisions:

- "Reason for appointment: 1. EXT #2"

- "Pt. presents to dental office for dental extraction of tooth #2."
- "Ext. tooth #2"
- "Tooth Sectioned and root tips removed separately."

10. The consent form patient GG signed on that date listed under consent to perform the following surgery: "Extraction # 2."

11. On Monday, November 14, 2016, patient GG returned to the offices of RHG and was treated by a third dentist in that practice, Dr. Charla McGough. The patient expressed a chief complaint of pain in upper right tooth, describing it as the one with the big cavity in it.

12. Dr. McGough notes that the patient chart prepared by Respondent indicates that tooth number 2 was removed on August 4, although from her visual observation tooth number 2 appeared to remain in his mouth.

13. Because of the discrepancy, a periapical radiograph was taken, and it confirmed Dr. McGough's visual observation that tooth number 3 was removed previously and tooth number 2 was still present in the mouth of patient GG.

14. Dr. McGough's note further states: "PT NEEDS TO BE INFORMED THAT #3 WAS TAKEN OUT (and could have been restored)."

15. Dr. McGough's diagnosis was: "#2 irreversible pulpitis with SAP."

16. Dr. McGough extracted tooth number 2 on November 14, 2016, consistent with the original treatment plan and diagnosis by Dr. Gonzales-Mugaburu on August 1.

17. The radiographs on November 14, 2016 also demonstrated that root tips from tooth number 3 remained in patient's GG's mouth.

18. Dr. McGough advised patient GG that a root tip from tooth number 3 was still in the socket but advised that it was best to wait until the root tip emerges to the surface.

19. Contemporaneous with her treatment of Patient GG on November 14, 2016, Dr. McGough informed RHG's Dental Director, Dr. Danielle English, about her observations and findings, including that at the August 4, 2016 appointment Respondent had extracted tooth number 3, rather than tooth number 2, as indicated in Respondent's treatment notes and as previously planned.

20. Dr. McGough did not discuss with patient GG Respondent's previous erroneous extraction of his tooth number 3, at the direction of Dr. English, who planned to inform him.

21. Respondent extracted the wrong tooth number 3, rather than number 2, at patient GG's August 4, 2016 appointment, as was discovered at his subsequent appointment at RHG on November 14.

22. Respondent failed to recognize and advise patient GG that she had removed the wrong tooth number 3 at the August 4 appointment.

23. There was no written informed consent or any other documentation in the treatment record for patient GG that he provided informed consent for Respondent to extract his tooth number 3 on August 4, 2016.

24. The only documentation concerning informed consent related to the extraction of tooth number 2 on August 4 by Respondent and again on November 14, 2016 by Dr. McGough.

25. Respondent failed to get patient GG's informed consent to remove tooth number 3 at the August 4 appointment.

26. In extracting tooth number 3 on August 4, Respondent also did not remove one of the root tips.

27. At the same August 4 appointment, Respondent failed to recognize that she did not remove a root tip and failed to advise patient GG that a root tip remained after extraction of tooth number 3.

28. After the November 14, 2016 appointment and her conversation with Dr. McGough, Dr. English communicated with Respondent and advised her that there was a problem with her treatment of patient GG and requested that she review the record.

29. On November 15, 2016, Respondent reviewed the treatment record for patient GG, including Dr. McGough's treatment note from November 14, indicating that Respondent had extracted the wrong tooth number from patient GG and that Respondent had left a root tip for tooth number 3.

30. Respondent has no recollection of the August 4, 2016 appointment with Patient GG.

31. After receiving Dr. English's communication and reviewing the treatment record for patient GG, including Dr. McGough's treatment note from November 14, Respondent created a fictitious entry in the patient record dated November 15 falsely indicating that it was tooth number 3 that was supposed to be extracted on August 4, 2016.

32. Respondent also created a related entry in the treatment record on the same date indicating that she had spoken with patient GG at approximately 5:30 PM on November 15 and that he allegedly confirmed she was supposed to remove tooth number 3 and not number 2 on August 4, 2016.

33. Respondent represented and testified that she created the-after-the fact notation in the treatment record based on a conversation with patient GG on November 15, 2016.

34. Dr. English reviewed the after-the-fact notation Respondent placed in the patient record on November 15 and then spoke with Patient GG the following morning, along with RHG's practice manager.

35. Dr. English prepared a record of her conversation with Patient GG on November 16, 2016, which she signed on the same day.

36. According to Dr. English's contemporaneous note and her subsequent testimony at the hearing, patient GG made the following statements to her when she initially contacted him by phone and then met with him in the office on the morning of November 16:

- "That tooth that was bothering me was pulled Monday."
- "I thought the wrong tooth was pulled in August because I was still hurting."
- "It was the tooth with the whole that needed to be pulled."
- "I told my girlfriend after I was here in August, I think the wrong tooth was pulled. I was still in pain."
- "I couldn't come back any earlier because I just started a new job, but this tooth has been hurting me since August."
- "Monday the right tooth was pulled not in August."

37. Patient GG made these comments before Dr. English indicated to him that the wrong tooth number 3 had been pulled at the August 4, 2016 appointment with Respondent.

38. Patient GG's most recent appointment at RHG, prior to this conversation with Dr. English, was with Dr. McGough on Monday, November 14 and his appointment with Respondent was in August.

39. Dr. English's contemporaneous signed notes also indicated that patient GG's statements to her on the morning of November 16 differed from the addendum added by Respondent on November 15, the previous evening.

40. Once confronted by others in the practice about her above conduct, Respondent repeatedly asserted to Dr. English and others at RHG that she had extracted the correct tooth number 3 on August 4 and falsely claimed that the error was just an improper entry on her patient record.

41. Dr. English filed a complaint against Respondent with the Board on or about December 13, 2016. According to her testimony, Dr. English submitted the complaint to the Board against Respondent based on her understanding of requirements in RHG's policy and governing federal law.

42. The Board sent Respondent notice of the complaint and allegations by letter dated December 28, 2016.

43. Respondent responded in writing to the complaint initially in a letter dated January 9, 2017, consisting of over 15 pages of narrative response.

44. Respondent filed a supplemental response with attachments, which was received by the Board on January 17, 2017. This supplemental response contained an additional 13 pages.

45. In her written responses to the Board, Respondent once again repeatedly reiterated her false statements and assertions that she had correctly removed patient GG's tooth number 3 on August 4.

46. Respondent made numerous detailed statements in her written responses about events that allegedly occurred during the August 4, 2016 appointment, about which she later admitted in testimony that she had no recollection.

47. For example, Respondent stated in her initial January 9, 2017 written response: "08/04 patient came in requesting tooth #3 to be pulled. #1-#3 all had large lesions but pt only wanted #3 addressed at this visit.".

48. In her testimony, Respondent acknowledged that she had no recollection of any statements made by patient GG during the August 4, 2016 appointment, including any regarding extraction of any specific tooth.

49. Additionally, Respondent stated in the initial written response: "Dr. Gonzalez had recommended a filling on tooth #3 but my patient assessment, symptoms and clinical evaluation when he presented on 08/04/2016 resulted in my agreeing with patient that tooth needed to come out. OS consent form was reviewed."

50. In her testimony, Respondent acknowledged that she had no recollection of the August 4, 2016 appointment and her contemporaneous treatment note contained no documentation of Respondent conducting a clinical evaluation of tooth number 3 on that date.

51. Respondent did not disclose or otherwise indicate in either of her lengthy written responses that she had no recollection of her treatment of patient GG on August 4, 2016.

52. In her written responses to the Board, Respondent cited to the fictitious and false entry in the patient record that she created in November 2016 allegedly to corroborate her false statements and assertions.

53. On July 15, 2017 Respondent attended a prehearing conference with the Board Investigative Panel concerning this matter. During that prehearing conference, Respondent again verbally repeated her false statements and assertions to the Investigative Panel and cited to the fictitious entry she had created in the patient record to cover up her prior errors and negligence.

54. Respondent repeated her false statements and assertions in sworn testimony at her deposition and again at the contested case hearing in this matter.

55. Based on the collective evidence presented at the hearing, including the contemporaneous treatment records and documentation from other dentists at RHG and the testimony of the witnesses, the Board Hearing Panel did not find to be credible or truthful Respondent's subsequent entry in the treatment record, her explanations, written responses to the Board and her testimony that she intended to extract patient GG's tooth number 3 at the August 4, 2016 appointment.

56. During this proceeding, Respondent made the following additional statements that the Board Hearing Panel did not find to be credible or truthful based on the collective evidence presented at the hearing:

- Respondent took or may have taken a postoperative x-ray of patient GG on August 4, 2016 but that x-ray may have been lost by RHG;

- There was no notation of a postoperative x-ray in her August 4, 2016 treatment note because Respondent had been instructed by RHG not to include postoperative x-rays in her treatment records;
- Respondent may have created an initial treatment record for patient GG on August 4, 2016 that was lost or deleted, and her alleged incorrect notation of the tooth number extracted in her treatment records may have resulted from her having to reenter the treatment notation later.

Based upon the foregoing Findings of Fact, the Dental Board enters the following:

CONCLUSIONS OF LAW

1. The N.C. State Board of Dental Examiners has jurisdiction over the subject matter of this action and over the person of Respondent.

2. Based on its collective experience, technical competence, and specialized knowledge, the Hearing Panel concludes that at the time of Respondent's treatment of patient GG the standard of care for dentists licensed to practice dentistry in North Carolina required dentists who extract teeth to possess and exercise the appropriate knowledge and skill required in performing these procedures, including:

a. obtaining the patient's proper informed consent for each tooth extracted,

b. extracting the correct tooth and not extracting the wrong tooth, and

c. removing all root tips, or, alternatively, recognizing any root tips not removed and advising the patient about whether to remove any remaining root tips.

3. Applying its collective experience, technical competence, and specialized knowledge to the evidence presented, the Board concludes that, in her treatment of Patient GG,

Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina, and thereby engaged in negligence in violation of G.S. § 90-41(a) (6) and (12) by failing to:

a. obtain patient GG's proper informed consent to extract tooth number 3,

b. extract the correct tooth number 2 and instead extracting the wrong tooth number 3 from patient GG, and

c. remove all root tips in extracting tooth number 3 from patient GG, recognize that a root tip for tooth number 3 was not removed, and advise patient GG about the remaining root tip.

4. Respondent engaged in unprofessional conduct and violated N.C. Gen. Stat. § 90-41(a)(6) and (26), and 21 NCAC 16V .0101(2), (14) and (24) by:

a) failing to file truthful responses to notice of the complaint from the Board;

b) presenting false or misleading statements or records to the Board, its investigator, or employees in her written responses and verbally at the prehearing conference concerning the complaint; and

c) making material false statements in communications with the Board or its agents regarding the subject of the pending disciplinary matter under investigation of her by the Board.

5. Respondent's violations warrant a suspension, but the public can be adequately protected by placing Respondent on a stayed suspension and provisionally restoring her license if she complies fully with various terms and conditions as set forth herein, including full future compliance with the Dental Practice Act and the Board's Rules and Regulations.

Based upon the foregoing Findings of Fact and Conclusions of Law, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

1. License No. 9953 issued to Respondent for the practice of dentistry in North Carolina is hereby suspended for a period of one (1) year. The active period of suspension is stayed, and Respondent's dental license is provisionally restored, provided Respondent complies with the following probationary terms and conditions for a period of five (5) years from the date of this Decision:

a. Respondent shall violate no provision of the Dental Practice Act or the Board's Rules and Regulations;

b. Respondent shall neither direct nor permit any of her employees to violate any provision of the Dental Practice Act or the Board's Rules;

c. Respondent shall permit the Board or its agents to inspect and observe her office, conduct a random review of patient chart records, and interview employers, employees, and co-workers at any time during normal office hours. The records review shall include clinical analysis of random patient charts by the Board Case Officer, and potentially an independent evaluator at his/her discretion, for a minimum of six continuous months without any violations indicated, which analysis shall begin after Respondent completes the continuing education course(s) in subsection (d) herein; and

d. Within eighteen months of signing this Order, Respondent shall complete the following continuing education course(s) of not less than 12 hours total, specially designed for her by the University of North Carolina or East Carolina School of Dentistry in conjunction with the North Carolina State Board of Dental Examiners directives and approved by it in advance, including a comprehensive, remedial course covering: (1) obtaining informed consent, proper procedures for extracting the correct teeth, and removing, recognizing, and advising patients about any remaining all root tips, (2) ethics and jurisprudence, including as to disclosures of errors, and (3) appropriate recordkeeping, including on electronic dental records utilizing the system used in Respondent's office at the time of the training. This requirement shall be in addition to the continuing education required by the Board for the renewal of Respondent's dental license. Respondent shall submit to the Board's Director of Investigators written proof of satisfactory completion of this course before it will be accepted in satisfaction of this requirement. It is Respondent's responsibility to make all arrangements for and bear the cost of this course within the specified time.

2. The Board recognizes that the conditions, limitations, or requirements set forth in this Decision may present Respondent with certain practical difficulties. The Board concludes that each one is necessary to ensure public protection and it does not intend to modify or eliminate any of the conditions, limitations, or requirements set forth herein based on such potential difficulties.

3. If Respondent fails to comply with any provision of this Decision or breaches any term or condition thereof, including those in paragraph one (1), the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent's suspension shall not be activated for violating a valid order of the Board. If after the Show Cause Hearing, the Board is satisfied that Respondent failed to comply or breached any term or condition of this Decision, the Board shall activate the suspension and also may enter such other discipline or conditions as the evidence warrants for proven violations of the Dental Practice Act or of the Board's Rules occurring after entry of this Decision.

This the 20th day of 2018, 2018.

Dr. Millard W. Wester, III
Hearing Panel Chair

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS