BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:  

Stephen C. Wallace, D.D.S.  
(License No. 4127)

FINAL AGENCY DECISION

THIS MATTER was heard before the North Carolina State Board of Dental Examiners ["Board"] on January 14-16, 2021, 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. Edward J. Clemons, Jr., presiding, Dr. Karen E. Lanier, Dr. William M. Litaker, Jr., Dr. Raleigh T. Wright, III, and Dr. Mark W. Johnson. Board member Dr. Millard W. Wester, III, served as the Investigative Panel's Case Officer. Dr. Wester and Board members Ms. Nancy A. St. Onge and Mr. Dominic Totman were present for the hearing but did not participate in the deliberation or decision of this matter. Kenneth Jones represented Respondent, Dr. Stephen Wallace ["Respondent"]. Douglas J. Brocker and Dauna L. Bartley 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 on July 21, 1975 and has held license number 4127 at all times relevant hereto.

3. Respondent obtained a moderate conscious sedation permit number 0145 on April 1, 1992 and held an active permit at all times relevant hereto through July 21, 2020.

4. Respondent is subject to the Dental Practice Act and the rules promulgated thereunder.

5. Respondent practiced as a periodontist in his dental office located in Wilmington, North Carolina at all times relevant hereto.

**Respondent’s Treatment of Patient Wayne W**

6. On December 9, 2016, a male patient, Wayne W, who was then 65 years old, presented to Respondent’s office for extraction of tooth #2 and ridge augmentation, and Respondent treated him under IV sedation [the "December 2016 procedure"].

7. Wayne W had been a periodontal patient of Respondent since late 2013.

**Respondent Failed to Recognize Wayne W’s Prior Sedation Problems**


9. During the first sedation procedure, according to his treatment records, Respondent administered sedative agents to Wayne W in the following total amounts:
   a. Diphenhydramine 50 mg/mL \( \cdot \) 0.5 mL \( = \) 25 mg
   b. Meperidine 50 mg/mL \( \cdot \) 2 mL \( = \) 100 mg
   c. Midazolam 5 mg/mL \( \cdot \) 4 mL \( = \) 20 mg
   d. Propofol 10 mg/mL \( \cdot \) 2.7 mL \( = \) 27 mg
   e. Ketamine 50 mg/mL \( \cdot \) 1 mL \( = \) 50 mg

10. During this first sedation procedure, there was more than a forty-minute period when Wayne W’s peripheral oxygen saturation [SpO2] levels either recorded on the monitor below 90% or failed to register any level of oxygen saturation.
11. Peripheral oxygen saturation at the levels recorded below 90% during this first procedure would be insufficient to profuse adequate oxygen to a person’s vital organs.

12. On November 12, 2014, Respondent again performed surgery under IV sedation on patient Wayne W.

13. During this second procedure, according to his treatment records, Respondent administered sedative agents to Wayne W in the following total amounts:
   a. Diphenhydramine 50 mg/mL .5 mL 25 mg
   b. Meperidine 50 mg/mL 2 mL 100 mg
   c. Midazolam 5 mg/mL 3 mL 15 mg
   d. Propofol 10 mg/mL 3 mL 30 mg

14. On August 26, 2015 [the “August 2015 procedure”], Respondent again performed surgery under IV sedation on patient Wayne W.

15. During the August 2015 procedure, according to his treatment records, Respondent administered sedative agents to Wayne W in the following total amounts:
   a. Diphenhydramine 50 mg/mL .5 mL 25 mg
   b. Meperidine 50 mg/mL 3 mL 150 mg
   c. Midazolam 5 mg/mL 1.5 mL 7.5 mg
   d. Propofol 10 mg/mL 2 mL 20 mg
   e. Ketamine 50 mg/mL 1 mL 50 mg

16. Wayne W demonstrated indicators that he was over-sedated during the August 2015 procedure, but Respondent failed to recognize these indicators of over-sedation.

17. For example, Wayne W experienced significant elevations in his blood pressure constituting a hypertensive event and contemporaneous oxygen saturation levels below 90% during the August 2015 procedure.

18. Wayne W also became agitated and restless while under sedative agents administered to him during the August 2015 procedure.

19. Because Wayne W became agitated under sedation during the August 2015 procedure, Respondent or his staff documented “no more sedation” in Wayne W’s patient record.
20. Respondent did not document in his sedation record the times and sequence of administration of the sedative agents administered to Wayne W during the August 2015 procedure.

21. On December 9, 2016 [the “December 2016 procedure”], Respondent performed surgery on Wayne W. The procedure was done under IV sedation per Wayne W's request.

22. Respondent did not record Wayne W's height, weight, body mass index, or airway classification for the December 2016 procedure or for prior procedures.

Respondent Failed to Obtain Informed Consent

23. Respondent did not provide Wayne W adequate information for him to provide informed consent to the December 2016 sedation and anesthesia procedure.

24. Although Wayne W signed a consent form prior to the December 2016 procedure, it was insufficient to provide informed consent for multiple reasons.

25. For example, Respondent's consent form required Wayne W to fast for 4 hours, which is clinically incorrect and insufficient.

26. A patient receiving anesthesia or sedation should withhold solid food for 6 hours and clear liquids for 2 hours.

27. Respondent's consent form thus asked Wayne W to consent to an anesthetic plan that put him at risk of aspiration and potentially death.

28. Prior to the December 2016 procedure, Respondent also failed to inform Wayne W concerning the common or rare risks, the side effects, or the alternatives to sedation or anesthesia.

29. At the time of Wayne W’s December 2016 and prior sedation procedures, Respondent’s general procedure with the consent form was to provide patients the consent form and have them sign it, which procedure remained up through the end of 2019.

30. Respondent generally did not have a discussion with patients about risks, benefits, and alternatives.

31. The primary basis for informed consent up through 2019 would be what was on the form that the patient signed.
32. Wayne W therefore could not and did not give informed consent for the anesthetic Respondent administered during the December 2016 procedure, nor the prior sedation procedures.

Respondent Administered a General Anesthetic and Maintained Inadequate Records

33. During the December 2016 procedure, according to his treatment records, Respondent administered sedative agents to Wayne W in the following total amounts:

   a. Diphenhydramine 50 mg/mL 1 mL 50 mg
   b. Meperidine 50 mg/mL 1 mL 50 mg
   c. Midazolam 5 mg/mL 3 mL 15 mg
   d. Propofol 10 mg/mL 3 mL 30 mg
   e. Ketamine 50 mg/mL

34. It is unclear from Respondent’s treatment record how much ketamine he administered to Wayne W during the December 2016 procedure, but 25 mg of ketamine was wasted or not administered.

35. Respondent did not document in his treatment record the exact dosages, times, and sequence of administration of the sedative agents administered to Wayne W nor correlate them to the times on the vitals monitor strip.

36. During the December 2016 procedure, Respondent administered agents, including propofol, meperidine, and midazolam, to Wayne W while also performing the surgical procedures on him.

37. The FDA-approved manufacturer drug labels for propofol and ketamine both state that these medications should be used only by providers trained in general anesthesia and advanced airway management.

38. Respondent holds a permit only for moderate conscious sedation. Respondent’s office was not permitted for general anesthesia.

Respondent Failed to Recognize and Properly Address Wayne W’s Medical Emergency

39. The times recorded on the monitor strip for the vital signs in the record do not correlate with the handwritten times recorded in Respondent’s treatment record about when other events occurred.
40. Respondent testified that from a review of other treatment records around the same time, he believed that the times recorded on the monitor strip were 30 to 40 minutes earlier than the actual time in the operatory during the December 2016 procedure.

41. The vital signs that are legible on the monitor strip in the anesthesia record show that Wayne W was hypoxemic during the procedure.

42. For example, according to the times and other information on the monitor strip in his treatment record, Wayne W’s peripheral oxygen saturation [SpO2] readings quickly dropped to dangerously low levels:

a. At 8:23 a.m., his SpO2 was 88%
b. At 8:27 a.m., his SpO2 was 88%
c. At 8:49 a.m., his SpO2 was 60%
d. At 8:53 a.m., his SpO2 did not register
e. At 8:56 a.m., his SpO2 was 71%
f. At 9:08 a.m., his SpO2 was 78%
g. At 9:23 a.m., his SpO2 did not register

43. Wayne W’s SpO2 readings indicate that for at least one hour his blood oxygen levels remained below the amount necessary to adequately perfuse his vital organs, including his heart, brain, and kidneys.

44. As his SpO2 readings indicate, Wayne W was hypo-ventilating and hypoxemic, and Respondent failed to recognize the complication and failed to ventilate him manually with a bag mask ventilator.

45. Respondent failed to recognize or take appropriate corrective action in response to Wayne W’s documented and observable distress.

46. The vital signs legible on the monitor strip in the anesthesia record show that Wayne W’s blood pressure and mean arterial pressure (MAP) fluctuated to dangerous extremes during the procedure:

a. At 8:23 a.m., his BP was 221/135 with a MAP of 171
b. At 8:27 a.m., his BP was 172/129 with a MAP of 153
c. At 8:49 a.m., his BP was 224/148 with a MAP of 181
d. At 8:53 a.m., his BP was 88/75 with a MAP of 83
e. At 8:56 a.m., his BP was 72/51 with a MAP of 65
f. At 9:08 a.m., his BP was 223/132 with a MAP of 168

47. Directly under the vital readings at 8:49 a.m., Respondent’s staff documented that the blood pressure cuff was changed.

48. Respondent failed to take proper corrective measures in response to Wayne W’s dangerous blood pressure levels and fluctuations.

49. Wayne W became agitated while under sedation during the December 2016 procedure, but Respondent did not document the time that Wayne W became agitated in relation to the times on the vitals monitor strip or in relation to the amounts of sedative agents administered.

50. Respondent observed that Wayne W became agitated and attempted to stand up.

51. Respondent documented in the anesthesia record that Wayne W was "restless, thrashing . . . ."

52. Respondent failed to recognize or take proper corrective measures upon observing this indication that Wayne W was over-sedated.

53. Instead of taking corrective measures, Respondent utilized an additional assistant to help restrain Wayne W and, at an undocumented time, Respondent intentionally administered additional undocumented amounts of anesthetic agents, including midazolam or ketamine.

54. After Respondent administered more anesthetic agents, his thrashing subsided and Respondent finished suturing the extraction site and performing the ridge augmentation.

55. Respondent’s intentional administration of more anesthetic agents resulted in inducing Wayne W into a level of deep sedation or general anesthesia.

56. Sometime after Respondent administered the additional amounts of anesthetic agents, Wayne W became unresponsive to Respondent or his staff at approximately 9:33 a.m.

57. At 9:33 a.m., Respondent administered an IV reversal agent, Flumazenil, to Wayne W, but it had no apparent effect.
58. Once Wayne W did not respond within a few minutes of administering the Flumazenil, Respondent realized something was wrong and he needed to contact emergency medical services ["EMS"] at that point.

59. Respondent did not, however, contact EMS at that point.

60. At 9:45 a.m., Respondent administered a corticosteroid to Wayne W, but it had no apparent effect.

61. Wayne W had no signs of an anaphylactic reaction, and Respondent admittedly had no justification for administering the corticosteroid to treat such a reaction.

62. According to Respondent, administering the corticosteroid was a "shot in the dark."

63. Corticosteroid was an incorrect treatment for an anaphylactic reaction, which Wayne W did not have or exhibit.

64. At approximately 10:09 a.m., Respondent's staff called 911 and requested EMS assistance, informing the 911 operator that the patient was "still unconscious" with "labored breathing" and "breathing problems."

65. Thirty-six (36) minutes elapsed between when Wayne W became unresponsive and when Respondent's office called for EMS.

66. EMS arrived at Respondent's office at 10:14 a.m., five minutes after Respondent's office contacted 911.

67. Forty-one (41) minutes elapsed between when Wayne W became unresponsive and when EMS first arrived at Respondent's office.

68. During those forty-one (41) minutes between when Wayne W became unresponsive and when EMS first arrived at his office, Respondent never:

   a. Administered positive pressure ventilation;

   b. Manually checked Wayne W for a pulse;

   c. Placed or utilized an AED to check for any heart rhythm; or

   d. Administered CPR to Wayne W.

69. The EMS paramedic first to arrive at Respondent's office observed that Wayne W was pulseless and not breathing.
70. The EMS paramedic observed no signs of intervention by Respondent or his staff, including no CPR being performed and no bag mask ventilator being utilized on Wayne W.

71. At some point during the forty-one (41) minutes between when Wayne W became unresponsive and when EMS first arrived at his office, Wayne W stopped breathing and lost his pulse, and Respondent failed to attempt Basic Life Support, Advanced Cardiac Life Support, or ventilation of Wayne W.

72. After determining he had no pulse, the EMS paramedic directed Respondent’s staff to begin CPR on Wayne W.

73. The EMS team placed a cardiac monitor on Wayne W, which indicated pulseless electrical activity ["PEA"] at a rate of 20 bpm.

74. PEA can result from prolonged periods of hypoxia within the myocardium.

75. EMS was unable to get a SpO2 reading from Wayne W upon arrival at the scene. The first SpO2 reading for Wayne W obtained by EMS at 10:20 a.m. was 32% after EMS initiated CPR and positive pressure ventilation on him.

76. In addition, at 10:20 a.m., Wayne W’s end-tidal carbon dioxide ["EtCO2"] reading was 67 mmHg, with the normal range between 35-45 mmHg.

77. The EMS team continued CPR, immediately initiated bag valve mask ventilation, placed a king airway, and administered epinephrine.

78. The EMS team eventually was able to get a return of spontaneous circulation and pulse for Wayne W and then transported him to New Hanover Regional Medical Center ["NHRMC"].

79. Wayne W was admitted to NHRMC within 24 hours of the December 2016 procedure and suffered an anoxic brain injury.

Respondent’s Treatment Resulted in Permanent Harm to Wayne W

80. In the hospital, Wayne W was diagnosed as having respiratory failure with hypoxia, acute kidney injury, encephalopathy, secondary hypertension, and anoxic brain injury.

81. Wayne W was intubated and placed on mechanical ventilation in the intensive care unit.
82. Wayne W did not suffer a myocardial infarction or other primary cardiac arrest.
83. Wayne W suffered from hypoxia leading to respiratory arrest and then subsequent cardiac arrest.
84. Wayne W’s hypoxia was caused by the anesthetic agents that Respondent administered to him and Respondent’s failure to address Wayne W’s hypoventilation.
85. Because of Respondent’s December 2016 sedation procedure and Respondent's failure to recognize and properly treat his hypoventilation, Wayne W suffered apnea, hypoxemia, hypoxia, cardiac arrest, acute kidney injury, encephalopathy, and anoxic brain injury.
86. Wayne W was in NHRMC for 10 days during which time he developed pneumonia.
87. Wayne W was in NHRMC intensive rehabilitation facility for an additional sixteen (16) days.
88. Upon discharge, Wayne W had cognitive deficits, incontinence, lower extremity strength deficit, memory deficits, among other limitations.
89. Wayne W suffered permanent organic brain dysfunction and physical injury related to and resulting from Respondent's December 2016 sedation procedure, which constituted an adverse occurrence.

Respondent Made False or Misleading Statements
90. Respondent did not submit an adverse occurrence report to the Board regarding Wayne W or the December 2016 procedure.
91. More than two years after the December 2016 procedure, the Board received notice of Wayne W’s adverse occurrence from another source resulting from a malpractice settlement.
92. By letter dated January 3, 2019, the Board through its Investigations Coordinator requested that Respondent provide information pertaining to his treatment of Wayne W.
93. By letter dated January 28, 2019 [the "Response Letter"], Respondent provided copies of his treatment records for Wayne W and made statements to the Board
through its Investigations Coordinator about his treatment of Wayne W, including the sedation procedure and resulting adverse occurrence.

94. Respondent made false or misleading statements or omissions to the Board in the Response letter or in his subsequent testimony.

95. For example, in his Response Letter, Respondent stated, "Prior to the arrival of EMS, [Wayne W] had a pulse and was breathing on his own. As the EMS team was entering the building, the patient stopped breathing and we immediately began CPR. The EMT staff then assumed the resuscitation efforts."

96. Moreover, Respondent testified that Wayne W had a pulse and was breathing up until EMS' arrival.

97. To the contrary, the EMS paramedic first to arrive at his office observed that there were no signs of intervention by Respondent or his staff, Wayne W was apneic and pulseless, and the paramedic directed Respondent's staff to begin CPR, which had not begun previously.

98. Wayne W's condition upon EMS' arrival was not consistent with a patient that had been breathing and had a pulse just before their arrival.

99. Additionally, in his Response Letter, Respondent stated that he administered a corticosteroid at 9:45 a.m., and then, "911 was contacted, and the EMS crew arrived within a few minutes thereafter."

100. Respondent later testified that his office contacted EMS within a few minutes after he administered a corticosteroid.

101. To the contrary, the EMS report the Board obtained after receiving the Response letter shows Respondent's office did not call 911 until 10:09 a.m., a critical twenty-four (24) minutes after administering the corticosteroid.

Applicable Standards of Care for Patient Wayne W

102. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Wayne W:

a. prohibited moderate conscious sedation permit holders from administering anesthesia medications that have a narrow margin of
safety and are likely to result in loss of consciousness, deep sedation, or general anesthesia;
b. required that dentists not administer anesthetic or sedative medications, either individually or collectively, that are intended or likely to induce a level of deep sedation or general anesthesia;
c. required that dentists obtain a client’s informed consent prior to administering anesthetic or sedative medications, including by properly instructing patients about the period for abstaining from solid food and liquid and informing them regarding the level of anesthetic and the corresponding risks and alternatives; and
d. required dentists to maintain adequate patient treatment records and sedations records that must include, among other information, (i) the drugs administered during a sedation procedure, including dosage, time, and sequence of administration and (ii) the patient’s respiration monitored during the procedure.

103. In his treatment of Wayne W during the December 2016 procedure and the August 26, 2015, November 12, 2014, and January 15, 2014 sedation procedures (Wayne W’s prior sedation procedures), Respondent repeatedly:
   a. administered anesthesia medications that had a narrow margin of safety and likely to result in loss of consciousness, deep sedation, or general anesthesia and therefore are contraindicated and unsafe for a moderate conscious sedation permit holder to administer;
   b. administered anesthetic or sedative medications, either individually or collectively, that were intended or likely to induce a level of deep sedation or general anesthesia;
   c. failed to obtain his informed consent, including by erroneously instructing him about the period for abstaining from solid food and by failing to inform him regarding the level of anesthetic and the corresponding risks and alternatives; and
   d. failed to maintain adequate treatment records and sedation records, including not including (i) the dosage, time, and sequence of drugs
administration, and (ii) the patient’s respiration monitored during the procedure.

104. During the December 2016 procedure, Respondent administered anesthetic or sedative agents that induced a level of deep sedation or general anesthesia and resulted in apnea, significant respiratory depression, hypoxemia, and hypoxia.

**Expert Witness Testimony and Evidence Concerning Wayne W**

105. The Investigative Panel presented the testimony of Dr. Dillon Atwood, D.D.S., and his related written report concerning Respondent’s treatment of Wayne W.

106. Dr. Atwood testified or presented evidence through his report that:

a. Respondent’s treatment of Wayne W violated the standard of care in numerous respects, including informed consent, anesthetic design, problem recognition, emergency management, and recordkeeping; and

b. These violations resulted in Wayne W suffering from apnea, hypoxemia, hypoxia, cardiac arrest, encephalopathy, acute kidney failure, and anoxic brain injury.

107. Dr. Atwood’s testimony on these issues was credible and compliant with Rule 702.

108. The Investigative Panel also presented the testimony of practicing periodontist, Jeffrey R. Thomas, D.D.S., and his related written report, concerning Respondent’s treatment of Wayne W.

109. Dr. Thomas also testified or presented evidence through his report that Respondent’s treatment of Wayne W violated the standard of care in numerous respects, including the amount and nature of the anesthetic or sedative medications administered, failure to properly monitor the patient, and failure to recognize and manage adverse events and the resulting medical emergency.

110. Dr. Thomas’s testimony on these issues was credible and compliant with Rule 702.

111. The Investigative Panel also presented the testimony of Dr. Robert Young, who was the Emergency Department physician that treated Wayne W at NHRMC after the December 9, 2016 procedure.
112. Dr. Young testified concerning his treatment of Wayne W and his opinions that the severe medical emergency that resulted in his admission to NHRMC was caused by respiratory failure secondary to sedation, leading to cardiac arrest and anoxic brain injury.

113. Dr. Young further testified that Wayne W’s medical emergency and resulting injuries definitely were not caused by a primary cardiac arrest or a heart attack.

114. Dr. Young’s testimony on these issues was credible and compliant with Rule 702.

115. Respondent did not offer expert testimony concerning his treatment and care of Wayne W.

**Additional Patients: Patterns of Sedation Treatment and Care**

116. As part of the investigation into Respondent’s treatment of Wayne W and his corresponding medical emergency, the Board’s Investigative Panel obtained from Respondent fifteen additional patient treatment records for patients undergoing surgical procedures with the administration of sedation, including Alice J, Andrea M, Barbara W, Billy B, Anne A, Patrick P, Glenda B, Jackie B, Jay E, Odell B, Peggy H, Robert J, Stewart M, Susie C, and Will E. [hereafter referred to collectively as, “fifteen additional patients”].

117. The treatment records demonstrated concerns about Respondent’s sedation treatment and care of all fifteen additional patients.

118. The fifteen additional patients’ records indicate that the issues with respect to Respondent’s treatment and care of Wayne W were part of a pattern that preceded and continued after the December 2016 procedure on Wayne W and his corresponding medical emergency and permanent injuries.

119. Specifically, in his care and treatment of the fifteen additional patients, Respondent engaged in a pattern of repeatedly:

   a. using anesthesia medications that have a narrow margin of safety, are designed for use and likely to induce deep sedation or general anesthesia and are contraindicated for use by moderate conscious sedation permit holders;
b. administering anesthetic or sedative agents, either individually or collectively, that were intended or likely to induce a level of deep sedation or general anesthesia and thereby increasing the risk of significant respiratory depression and corresponding medical conditions if not addressed promptly;

c. failing to obtain patients' informed consent for sedation procedures;

d. failing to adequately assess and evaluate a patient for health risks, including making and recording an appropriate ASA determination, before administering sedation and performing surgery; and

e. failing to maintain adequate patient treatment and sedation records.

120. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated the fifteen additional patients were the same as set forth in para. 102, as well as requiring that a dentist adequately assess and evaluate a patient for health risks, including making and recording an appropriate ASA determination, before administering sedation and performing surgery.

121. Respondent regularly administered propofol to patients for at least nine years from at least 2008 to 2017.

122. In any instance in which Respondent administered propofol to patients identified in the Notice of Hearing, Respondent did not have a CRNA or an anesthesiologist present during the procedures.

123. In all those instances, Respondent performed both the surgical or periodontal procedure and administered propofol during the same procedure.

124. Respondent regularly administered ketamine to patients for at least nine years from at least 2010 to 2019.

125. In any instance in which Respondent administered ketamine to a patient identified in the Notice of Hearing, Respondent did not have a CRNA or an anesthesiologist present during the procedures.

126. Both prior to and after the December 2016 procedure on Wayne W, Respondent repeatedly administered propofol and ketamine to the fifteen additional patients.
127. Propofol and ketamine have a narrow margin of safety, are designed for use and likely to induce deep sedation or general anesthesia, and are contraindicated for use by moderate conscious sedation permit holders.

128. From at least 2014 to 2019, Respondent administered to multiple additional patients anesthetic or sedative agents, either individually or collectively, that were intended or likely to induce a level of deep sedation or general anesthesia.

129. In addition to propofol and ketamine, the medications Respondent administered to the additional patients included midazolam, meperidine, and fentanyl, among others.

130. According to the FDA-approved drug label for midazolam:
   a. “Serious cardiorespiratory adverse events have occurred after administration of midazolam. These have included respiratory depression, airway obstruction, oxygen desaturation, apnea, respiratory arrest and/or cardiac arrest, sometimes resulting in death or permanent neurologic injury.”
   b. “Patients should be continuously monitored for early signs of hypoventilation, airway obstruction, or apnea, with means readily available (e.g., pulse oximetry). Hypoventilation, airway obstruction, and apnea can lead to hypoxia and/or cardiac arrest unless effective countermeasures are taken immediately.”
   c. “Intravenous midazolam has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings. In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted.”
   d. “Adult patients undergoing procedures involving the upper airway such as upper endoscopy or dental care, are particularly vulnerable to episodes of desaturation and hypoventilation due to partial airway obstruction.”
e. “Concomitant use of benzodiazepines, including midazolam, and opioids may result in profound sedation, respiratory depression, coma, and death.”

f. “When benzodiazepines and opioids are combined, the potential for benzodiazepines to significantly worsen opioid-related respiratory depression exists,” with meperidine and fentanyl specially referenced.

131. From at least 2016 through 2019, in his treatment and care of some or all fifteen additional patients, Respondent failed to:

a. adequately assess and evaluate patients for health risks, including making and recording an appropriate ASA determination, before administering sedation and performing surgery;

b. obtain informed consent prior to sedation procedures; and

c. maintain adequate patient treatment and sedation records.

Expert Testimony on Additional Patients


133. Dr. Atwood testified or presented evidence through his report that Respondent’s assessment, treatment, monitoring, or recordkeeping concerning these fifteen patients, both before and after Wayne W’s December 2016 procedure, demonstrated a pattern of violations of the standard of care and the Board’s regulations, including some of the same violations involved in his treatment of Wayne W.

134. Dr. Atwood’s testimony on these issues and the pattern of violations by Respondent was credible and compliant with Rule 702.

135. Respondent did not offer any expert witness testimony concerning his treatment of the fifteen additional patients.

CONCLUSIONS OF LAW
1. The Board has jurisdiction over Respondent and over the subject matter of this case.

2. The Board’s regulations in effect and applicable at the times Respondent treated Wayne W in 2014-16 and continuing up through May 31, 2017 provided that:
   a. In administering conscious sedation, “the drugs or techniques used shall carry a margin of safety wide enough to render unintended loss of consciousness unlikely.” 21 NCAC 16 Q 0101(7);
   b. “A dentist who holds a moderate conscious sedation . . . permit shall not intentionally administer deep sedation although deep sedation may occur briefly and unintentionally.” 21 NCAC 16 Q .0301(i); and
   c. A dentist administering moderate conscious sedation must maintain records for at least ten years that include: “drugs administered during the procedure, including route of administration, dosage, strength, time and sequence of administration” and a sedation record including the patient’s “respiration.” 21 NCAC 16 Q .0302(a)(6)(B) and (C)(iii).

3. Respondent violated the Board’s applicable regulations and the standard of care for dentists licensed to practice dentistry in North Carolina in his treatment and care of Wayne W, as set forth in Findings of Fact 6-114.

4. The Board’s regulations in effect and applicable at the time Respondent treated Wayne W in December 2016 provided that: “A dentist who holds a permit to administer general anesthesia or sedation shall report to the Board within 30 days after each adverse occurrence related to the administration of general anesthesia or sedation that results in permanent organic brain dysfunction of a patient occurring within 24 hours of the procedure or that results in physical injury or severe medical emergencies, causing hospitalization of a patient occurring within 24 hours of the procedure.” 21 NCAC 16 Q .0703(b).

5. Respondent violated 21 NCAC 16 Q .0703(b) by never reporting to the Board the adverse occurrence related to his administration of sedation to Wayne W during the December 2016 procedure, resulting in Wayne W’s physical injury, permanent organic brain dysfunction, and severe medical emergency causing hospitalization within 24 hours of the procedure, as set forth in Findings of Fact 79-90.
6. In his treatment and care of Wayne W, as set forth in Findings of Fact 6-114 and Conclusions of Law 2-5, Respondent:
   a. was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12);
   b. committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19); and
   c. violated the Board’s rules concerning moderate conscious sedation procedure, record keeping, and reporting an adverse occurrence set forth in 21 NCAC 16Q .0101, .0301, .0302, and .0703 and thereby violated N.C. Gen. Stat. § 90-41(a)(6).

7. The Board’s regulations, which were in effect and applicable at the time of the contested case hearing and when Respondent sent his Response Letter to the Board about Wayne W's December 2016 sedation procedure, defined as unprofessional conduct: “Presenting false or misleading testimony, statements, or records to the Board or the Board’s investigator or employees during the scope of any investigation or any hearing of the Board.” 21 NCAC 16V .0101(2).

8. Respondent presented false or misleading testimony, statements, or records to the Board during the scope of its investigation and in the hearing before the Board concerning his treatment and care of Wayne W, as set forth in Findings of Fact 90-101, and thereby engaged in unprofessional conduct in violation of N.C. Gen. Stat. § 90-41(a)(26) and 21 NCAC 16V .0101(2).

9. The Board regulations in effect from June 1, 2017 to the present provide that:
   a. “a moderate conscious sedation provider shall not use the following: (a) drugs designed by the manufacturer for use in administering general anesthesia or deep sedation; or (b) drugs contraindicated for use in moderate conscious sedation.” 21 NCAC 16V .0101(29);
   b. “A dentist who holds a moderate conscious sedation permit shall not intentionally administer deep sedation.” 21 NCAC 16V .0301(f); and
   c. A dentist administering moderate conscious sedation must maintain records for at least ten years that include: “drugs administered during
the procedure, including route of administration, dosage, strength, time and sequence of administration” and a sedation record including the patient’s “respiration rate.” 21 NCAC 16 Q .0302(a)(4)(B) and (5)(A).

10. Respondent engaged in a pattern of violating the Board’s applicable regulations and the standard of care for dentists licensed to practice dentistry in North Carolina in his treatment and care of the fifteen additional patients from at least 2016-19, as set forth in Findings of Fact 116-134.

11. With respect to his assessment and treatment of the fifteen additional patients as set forth in Findings of Fact 116-134 and Conclusions of Law 2, 9 and 10, Respondent:

   a. engaged in negligence in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12); and

   b. violated the Board’s rules concerning moderate conscious sedation procedure and record keeping including 21 N.C.A.C. 16Q .0101, .0301, and .0302, and thereby violated N.C. Gen. Stat. § 90-41(a)(6).

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 relevant to the appropriate discipline to impose for the violations found and to protect the public:

**ADDITIONAL FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE**

1. The Board’s disciplinary factors regulation, 21 NCAC 16N .0607, applies to this contested case hearing, which was commenced after the effective date of the rule, October 1, 2019.

2. Respondent’s violation of the Board’s regulations and the standard of care in his treatment of patient Wayne W caused or contributed to his physical injury, permanent organic brain dysfunction, and severe medical emergency requiring hospitalization. This factor required the Board to consider revocation of his dental license, sedation permit, or both. 21 NCAC 16N .0607(1)(a).
3. Respondent’s violations resulted in harm or potential harm to his patients, the public, or the dental profession. This factor required the Board to consider revocation or suspension of his dental license, sedation permit, or both. 21 NCAC 16N .0607(2)(d).

4. Respondent committed multiple instances of negligence or malpractice in treating patients. This factor also required the Board to consider revocation or suspension of his dental license, sedation permit, or both. 21 NCAC 16N .0607(2)(h).

5. Respondent’s violations had a significant negative effect on patient Wayne W, his wife, family, and others. 21 NCAC 16N .0607(3)(a).

6. Respondent did not have a dishonest and selfish motive for the violations found in his treatment of Wayne W and the additional fifteen patients. 21 NCAC 16N .0607(3)(d).

7. Respondent engaged in a pattern of violations of the Board’s regulations and the applicable standard of care. 21 NCAC 16N .0607(3)(e).

8. Respondent committed acts, including administering general anesthesia medications and other sedative medications in amounts and combinations, where the harm or potential harm was foreseeable. 21 NCAC 16N .0607(3)(f).

9. Respondent consistently refused to acknowledge the wrongful nature of his violations and attempted to place responsibility or blame on others for his violations and the effect of them. 21 NCAC 16N .0607(3)(k).

10. Respondent’s violations and other actions had a negative impact on patient Wayne W or the public’s perception of the dental profession. 21 NCAC 16N .0607(3)(l).

11. Respondent demonstrated a lack of remorse for his violations and the effect of those violations on patient Wayne W and others. 21 NCAC 16N .0607(3)(q).

12. Respondent had extensive experience in the practice of dentistry and administration of sedation prior to the violations found. 21 NCAC 16N .0607(3)(t).

13. The Hearing Panel considered all remaining factors set forth in 21 NCAC 16N .0607 and determined that the following factors are not applicable or relevant to the discipline in this case: 1(b) and (c); 2(a)-(c), (e)-(g), and (i)-(l); and (3)(b), (c), (g)-(j), (m)-(p), (r), (s), and (u).

14. More than two years after the December 9, 2016 incident involving Wayne W, Respondent implemented significant changes in several aspects of his practice,
including updated and revised informed consent forms, updated and revised sedation/anesthesia records, updated and revised emergency manual, new sedation monitoring equipment, and more stringent NPO requirements for sedation patients.

15. Violations of the Board’s regulations concerning administration of sedation and anesthesia “may result in suspension or revocation of the permit and/or the dentist’s license to practice dentistry in accordance with G.S. 90-41.” 21 NCAC 16Q .0701.

16. Based the findings, conclusions, pattern and extent of violations, and applicable disciplinary factors:
   a. Respondent poses a significant risk to the public in administering sedation and should be disqualified from holding any level of sedation permit and prohibited from administering any level of sedation in North Carolina that requires a permit;
   b. Respondent’s numerous and compounded acts of negligence and numerous other violations related to the administration of sedation were not caused by and did not result from a lack of training or inadequate training and, consequently, additional education and training cannot remediate his violations adequately; and
   c. Any lesser discipline other than revocation of his sedation permit would be insufficient to protect the public, even if Respondent obtained additional education or training concerning sedation issues; and
   d. Protection of the public requires revocation of Respondent’s sedation permit.

17. Based on the findings, conclusions, pattern and extent of violations, and applicable disciplinary factors:
   a. Protection of the public does not require revocation of Respondent’s dental license, in part because Respondent does not lack good moral character nor lack competence concerning essential aspects of his dental practice;
   b. Protection of the public requires suspension of Respondent’s dental license and any lesser discipline would be insufficient because Respondent’s numerous, compounded acts of negligence and
numerous other violations demonstrate that he poses a risk to the public extending beyond administration of sedation and to other aspects of his dental treatment for patients; and

c. The public should be adequately protected, however, if the suspension of Respondent’s dental license is stayed, he can continue to practice dentistry, but not administer sedation, so long as he complies with various probative terms and conditions.

18. The nature, pattern, and extent of Respondent’s violations concerning his treatment of Wayne W alone, even without the violations concerning the additional patients, warrant the revocation of his sedation permit and the suspension of his dental license reinstated on various terms and conditions.

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

1. Respondent’s moderate conscious sedation permit number 0145 is REVOKED. The revocation of Respondent’s moderate conscious sedation permit is effective upon service of this Final Agency Decision. Respondent shall immediately surrender his permit upon service of this Final Agency Decision.

2. Respondent shall not supervise a certified registered nurse anesthetist (CRNA) or any other person in administering sedation. Respondent may utilize the service of an independent provider of anesthesia that does not require supervision, such as an itinerate permit holder consistent with the Board’s regulations in 21 NCAC 16Q.

3. License 4127 issued to Respondent for the practice of dentistry in North Carolina is suspended for a period of five (5) years. The suspension shall be immediately stayed, and Respondent’s dental license shall remain active, provided that for five (5) years from the effective date of this Order, Respondent adheres to the following probationary terms and conditions:
a. Respondent shall violate no provision of the Dental Practice Act or the Dental Board regulations.

b. Respondent shall neither direct nor permit any of his employees to violate any provision of the Dental Practice Act or the Board’s regulations.

c. Respondent shall permit the Board or its agents to inspect and observe his office, conduct a random review of patient chart records, and interview employers, employees, and coworkers at any time during normal office hours.

d. Within one year from the date of this Order, Respondent shall complete a continuing education course covering creating and maintaining adequate and complete patient treatment records that is especially designed for him by the University of North Carolina School of Dentistry or East Carolina School of Dentistry in conjunction with, and approved in advance by, the North Carolina State Board of Dental Examiners. This requirement shall be in addition to the continuing education required by the Board for renewal of Respondent’s dental license. Respondent shall submit to the Board’s Director of Investigations written proof of satisfactory completion of the course before it will be accepted in satisfaction of this requirement. It is the Respondent’s responsibility to make all arrangements for and bear the costs of this course within the specified time frame.

4. The Board recognizes that the conditions, limitations, or requirements set forth in this Order may present Respondent with certain practical difficulties but 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.

5. If Respondent fails to comply with any provision of this Decision and Order or breaches any term or condition thereof, including those in paragraph three, the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent’s suspension of his dental license 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 with or breached any term or condition of this Decision, the Board shall activate the suspension of his dental license and 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 13th day of April 2021.

Dr. Edward J. Clemons, Jr., Presiding Officer on behalf of the Hearing Panel
The N.C. State Board of Dental Examiners