BEFORE THE ARIZONA STATE BOARD OF DENTAL EXAMINERS

In the Matter of: **MICHAEL D. MARGOLIS, DDS** Holder of License No. **D2957** For the Practice of Dentistry In the State of Arizona RESPONDENT	**CASE NOS. FY-18-201600123-DEN** **FY18-201700164-DEN** **DECISION AND ORDER**

This matter came before Jenna Clark, Administrative Law Judge (ALJ) for the Office of Administrative Hearings on June 11-14, 2018 and August 16, 2018, for the purpose of determining whether good cause exists for the Arizona State Board of Dental Examiners ("Board") to discipline Michael D. Margolis, DDS ("Respondent). David Williams, Esq. appeared on behalf of Michael D. Margolis, D.D.S. ("Respondent"), with Jerry Bouquet, Boyd Haley, Thomas Levy, Stephen Evans, Joseph Thomas, and Respondent as witnesses. Assistant Attorney General Mary DeLaat Williams, Esq. appeared on behalf of the Arizona State Board of Dental Examiners ("the Board"), with Elaine Hugunin[1], Michael Mansfield, and Brown Harris as witnesses.

On February 1, 2019, the Board reviewed the record in this matter including the hearing exhibits and the ALJ's recommended Decision, dated November 15, 2018. The Respondent was present at the Board's meeting. Assistant Attorney-General Ms. DeLaat-Wiliams was present and requested that the Board adopt the ALJ's Findings of Fact, Conclusions of Law and Recommended Order along with modifications by the State. Attorney for the Respondent, Mr. Williams made oral arguments for the Board to adopt the ALJ Decision as ordered. Elizabeth Campbell, Esq., Assistant Attorney General with the Solicitor General's office was present to provide independent legal advice to the Board and to limit the parties to the record submitted only at the hearing. Pursuant to A.R.S. §41-1092.08(B), which states that the Board may accept, reject or modify the decision,

[1] Elaine Hugunin retired as Executive Director for the Board effective July 17, 2018. Nancy Chambers, who was appointed as Acting Executive Director after Ms. Hugunin retired, appeared as the Board's representative at the August 16, 2018, hearing. Ms. Chambers did not testify.

the Board voted to modify the ALJ's Findings of Fact, the ALJ's Conclusions of Law and the ALJ's Recommended Order. Based on the ALJ's Recommended Decision, the administrative record in this matter and the Board meeting, the Board issues the following Order:

FINDINGS OF FACT

BACKGROUND AND PROCEDURE

1. Respondent is holder of License No D2957, issued on June 22, 1983, for the practice of dentistry in the State of Arizona.

2. The Board has the authority to regulate and control the practice of general dentistry in the State of Arizona[2].

3. On October 17, 2017, the Board issued a COMPLAINT AND NOTICE OF HEARING for Case No. 201600123 alleging that Respondent had engaged in unprofessional conduct pursuant ARIZ. REV. STAT. §§ 32-1201.01 (14) ("Any conduct or practice that constitutes a danger to the health welfare or safety of the patient or the public."); 32-1201.01(4) (Gross malpractice, or repeated acts constituting malpractice."); and 32-1201.01(16) ("Repeated irregularities in billing," as defined in ARIZ. REV. STAT. § 32-1201(13)). Respondent was further advised that the aforementioned alleged conduct constituted grounds for disciplinary action, including suspension or revocation of Respondent's dental license, pursuant to ARIZ. REV. STAT.12 § 32-1263(A)(1).

4. Respondent's ANSWER to the COMPLAINT was timely received by the Board. On April 17, 2018, the Board issued a COMPLAINT AND NOTICE OF HEARING for Case No. 201700164 alleging that Respondent had engaged in unprofessional conduct pursuant ARIZ. REV. STAT. §§ 32-1201.01(14) ("Any conduct or practice that constitutes a danger to the health, welfare or safety of the patient or the public."); 32-1201.01 (16) ("Repeated irregularities in billing." as defined in ARIZ. REV. STAT. § 32-1201(13)); 32-1201.01(24) ("Failing or refusing to maintain adequate patient records."); and 32-1264(A) (Maintenance of records.). Respondent was further advised that the aforementioned alleged conduct constituted grounds for disciplinary action,

[2] See ARIZ. Rev. STAT. § 32-1201 *et seq.*

including suspension or revocation of Respondent's dental license, pursuant to ARIZ. REV. STAT. § 32-1263(A)(1) and (4).

5. Respondent's ANSWER to the second COMPLAINT was also timely received by the Board.

6. The two cases were consolidated by the Board for efficiency.

7. Because Respondent contested[3] the charges in both COMPLAINTS[4], the Board forwarded the consolidated matters to the Office of Administrative Hearings, an independent state agency, with a CONSOLIDATED NOTICE OF HEARING set for December 04, 2018, through December 07, 2017. For administrative reasons the hearing was continued and ultimately heard June 11, 2018, through June 14, 2018, and August 16, 2018, to determine whether Respondent violated ARIZ. REV. STAT. §§ 32-1201.01(14), 32-1201.01(16), 32-1201.01(24), and 32-1264(A) as charged by the Board in both cases.

Case No. 201600123: TK's Case

8. On the recommendation of her physician TK first presented at Respondent's office for an initial examination on May 27, 2014. Respondent performed an initial examination whereby he performed an oral examination, employed the use of cone beam computed tomography ("CBCT" or 113D Cone Beam")[5] , and also used a Cavitat ultrasound device to diagnose TK with Neuralgia-Inducing Cavitatlonal Osteonecrosis ("NICO")[6]

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[3] "Contested case" means any proceeding in which the legal rights, duties or privileges of a party are required to be determined by an agency after an opportunity for an administrative hearing. ARIZ. Rev. STAT.§ 41-1001(4). Contested cases must be set within sixty days of the agency's request for a hearing. ARIZ. Rev. STAT. § 41-1092.05(A)(2). "Appealable agency action" means an action that determines the legal rights, duties or privileges of a party and that Is not a contested case. ARIZ. Rev. STAT. § 41-1902(3). Appealable agency actions must be set within sixty days of the licensee's notice of appeal. ARIZ. REV. STAT.§ 41-1092.05(A)(1).

[4] On November 21, 2017, an informal settlement conference was held at the Board's offices but the parties did not resolve their dispute. The parties did not participate in any additional informal settlement conferences regarding either case.

[5] CBCT, or 30 Cone Beam, is a medical imaging technique where the X-rays are divergent, forming a cone.

[6] Ischemic (decrease in blood supply to an area or organ due to constriction or obstruction of blood vessels) osteonecrosis (death of bone tissue) is a common disease affecting boney parts of the human body, but Is specifically referred to as NICO when It occurs in the jawbone. By definition, NICO is associated with pain.

9. Respondent noted on TK's patient chart that crowns on teeth numbers 2[7] and 3 were discolored, and that tooth number 31 was ready to have a crown placed[8].

10. Respondent gave TK a Cavitat presentation and presented the results of her 3D Cone Beam examination to her.

11. Respondent reviewed several courses of treatment with TK. Respondent ultimately recommended a cavitation even though TK did not indicate that she had any pain, because Respondent believed TK's radiograph results indicated that she had bone density loss consistent with ischemic osteonecrosis.

12. On September 23, 2014, Respondent removed TK's metal crowns on teeth numbers 2 and 3. Respondent noted "no mercury present on TK's chart. On October 29, 2014, Respondent replaced crowns on teeth numbers 2 and 3.

13. On October 01, 2014, Respondent issued a Treatment Plan for TK based on the results from her initial examinations. The plan included the extraction of the implant at tooth number 31.

14. TK signed a consent form, which also contained a disclaimer, for treatment that same day.

15. On October 03, 2014, Respondent extracted teeth numbers 14, 15, 18, and 19 from TK, and billed for peripheral ostectomies and alveoloplasties around said teeth[9]. 10 Respondent also performed peripheral ostectomies and billed for alveoloplasties around teeth numbers 16 and 17.

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[7] Adults naturally grow thirty-two teeth in their mouths, barring any medical complications. Among these teeth are eight incisors, four canines, eight premolars, and twelve molars; including four wisdom teeth. However, because many adults have had their wisdom teeth removed, they have twenty-eight teeth as a result (presuming no other teeth have been removed or lost), Teeth are also numbered. Tooth number 1 is the tooth farthest back on the right side of the mouth in the upper (maxillary) jaw. Numbering continues along the upper teeth towards the front and across to the tooth farthest back on the top left side number 16. The numbers continue by dropping down to the lower (mandibular) Jaw. Number 17 is the tooth farthest back on the left side of the mouth on the bottom. Numbering continues again toward the front and across to the tooth farthest back on the bottom right side of the mouth number 32.

[8] At the hearing, Respondent testified that TK had corrosion between teeth numbers 2 and 3, a condition created by the presence of dlsslmilar metals in the oral cavity of the teeth where saliva serves as the electronic galvanizer, but TK's chart did not reflect any such notation. See TK File, page 118.

[9] Peripheral ostectomy refers to the removal of bone surrounding a tooth. An alveoloplasty Is a surgical procedure used to smooth and reshape a patient's jawbone in areas where teeth have been extracted or otherwise lost.

Additionally, Respondent collected samples of blood, crystalized bone, and fatty tissue from teeth numbers 14 through 19 for biopsy.

16. Samples taken from TK were sent for biopsies at Dental DNA[10].

17. Respondent believed the removal of portions of TK's jawbone and the reshaping of the removed areas were two separate procedures, so he billed TK for alveoloplasties on all six teeth.

18. On December 10, 2014, Respondent removed TK's implant at tooth number 31, and billed for a peripheral ostectomy and alveoloplasty around that tooth. Respondent billed for peripheral ostectomies and alveoloplasties around teeth numbers 1 and 32. Additionally, Respondent collected samples of blood, crystalized bone, and fatty tissue from teeth numbers 1, 31, and 32 for biopsy.

19. Samples taken from TK were sent for biopsies at Dental DNA.

20. Respondent believed the removal of portions of TK's jawbone and the reshaping of the removed areas were two separate procedures, so he billed TK for alveoloplasties on teeth numbers 1, 31, and 32.

21. On March 31, 2015, Respondent performed a sinus lift on TK. Respondent then placed implants where teeth numbers 14, 15, 18, and 19 had been extracted.

22. On or about September 09, 2015, Respondent seated a crown on tooth number 19.

23. In March of 2016 TK notified Respondent that she was terminating her status as a patient.

24. TK filed a complaint with the Board on July 21, 2016, whereby she alleged that the implants Respondent had placed were inadequate[11].

25. The Board initiated an investigation as a response.

26. Based on information obtained during the course of its investigation, the Board added the following allegations to TK's complaint: inadequate diagnosis and treatment planning,

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[10] Dental DNA analysis Is used to Identify bacteria present In samples, unlike histological pathology tests which study spliced tissue microscopically in order to Identify the manifestations of disease.

[11] To protect patient privacy the oomplaining party shall be referenced solely by their initials.

inadequate oral surgery, inadequate crown and bridge, billing irregularities, and use of drugs not approved by the Food and Drug Administration.

Case No. 201700164: MT's Case

27. On the recommendation of her physician, MT went to Respondent's office for an initial examination on February 17, 2015, because she wanted Respondent to examine a root canaled tooth and determine whether she was a candidate for implants. Respondent performed an initial examination whereby he employed the use of an oral examination, cone beam computed tomography ("CBCT" or 3D Cone Beam"), and a Cavitat ultrasound device to diagnose MT with neuralgia-inducing cavitational osteonecrosis ("NICO").

28. Respondent gave MT a Cavitat presentation and presented the results of her 3D Cone Beam examination to her.

29. Respondent reviewed several courses of treatment with MT. Respondent ultimately recommended a cavitation even though MT did not indicate that she had any pain, because her radiograph results indicated that she had bone density loss consistent with ischemic osteonecrosis.

30. On February 17, 2015, Respondent created a Treatment Plan for MT based on the results from her initial examinations.

31. MT signed a consent and disclaimer form for treatment that same day.

32. On February 18, 2015, Respondent extracted tooth number 3 (the root canaled tooth) from MT, and also performed peripheral ostectomy and billed for an alveoloplasty around said tooth[12]. Respondent also performed peripheral ostectomies and billed for alveoloplasties around teeth numbers 1, 31 and 32. Additionally, Respondent collected samples of blood, crystalized bone, and fatty tissue from teeth numbers 1, 3, 31 and 32 for biopsy.

33. Samples taken from MT were sent for biopsies at Dental DNA[13].

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[12] Peripheral ostectomy refers to the removal of bone surrounding a tooth. An alveoloplasty Is a surgical procedure used to smooth and reshape a patient's jawbone in areas where teeth have been extracted or otherwise lost.

[13] Dental DNA analysis Is used to identify bacteria present in samples, unlike histological pathology tests which study spliced tissue microscopically in order to identify the manifestations of disease.

34. Respondent believed the removal of portions of MT's jawbone and the reshaping of the removed areas were two separate procedures, so he billed MT for alveoloplasties on all four teeth.

35. On July 08, 2015, Respondent performed peripheral ostectomies and billed for alveoloplasties around teeth numbers 16, 17, 18 and 19. Additionally, Respondent collected samples of blood, crystalized bone, and fatty tissue from teeth numbers 16, 17, 18 and 19 for biopsy.

36. Samples taken from MT were sent for biopsies at Dental DNA.

37. Respondent billed MT for alveoloplasties on teeth numbers 16, 17, 18 and 19.

38. Respondent believed the removal of portions of MT's jawbone and the reshaping of the removed areas were two separate procedures, so he billed MT for alveoloplasties on all four teeth.

39. MT filed a complaint with the Board on August 11, 2017, whereby she alleged that Respondent had placed inadequate crowns and implants. MT also alleged that Respondent had performed unnecessary treatments on her.

40. The Board initiated an investigation as a response.

41. Based on information obtained during the course of its investigation, the Board added the following allegations to MT's complaint: improper patient recordkeeping, improper billing, inadequate diagnosis and treatment planning, and inadequate oral surgery.

HEARING EVIDENCE

42. At the hearing, Ms. Williams presented witnesses Elaine Hugunin ('Director Hugunin"), Michael Mansfield, D.M.D. ("Dr. Mansfield"), and Brown Harris,D.D.S. ("Dr. Harris") for the Board. The Board submitted exhibits 1-11[14]. Mr. Williams presented witnesses Jerry Bouquot, D.D.S. M.S.D. ("Dr. Bouquot"), Boyd Haley, Ph.D. ("Dr. Haley"), Thomas Levy, M.D. J.D. ("Dr. Levy"), Stephen Evans, D.D.S. ("Dr.Evans), Joseph Thomas, D.D.S. M.A.G.D.

[14] Hearing Exhibit 1 - Bates Nos. Hearing000001-Hearlng000966 and Hearing Exhibit 2 - Bates Nos. MT000001-MT000607 are designated as non-public under ARIZ. REV. STAT.§ 32-1263.02(K).

("Dr. Thomas") for Respondent. Respondent also testified on his own behalf. Respondent submitted exhibits A-M.

Director Hugunin's testimony

43. Director Hugunin testified that the Board's primary directive is to protect the public[15]. She described the investigation process as follows: Records are subpoenaed and Respondent is permitted to respond to the gathered information; the sum total of the gathered information is sent to an outside consultant; the consultant provides a recommendation after reviews all of the provided information; and then the consultant's recommendation and case file are presented to the Board. Director Hugunin testified that in T.K.'s case, the Board voted to refer the matter to the Office of Administrative Hearings following a formal interview with Respondent; in MT's case, Respondent and his attorney requested the case proceed to the Office of Administrative Hearings in lieu of a formal interview before the Board.

CASE No. 201700164: MT'S CASE

Dr. Mansfield's testimony

44. Dr. Mansfield is an oral surgeon who specializes in Maxillofacial surgery. Dr. Mansfield has four certifications, including one from the American Board of Oral/Maxillofacial surgery, and has had several academic appointments. Dr. Mansfield has also published several peer-reviewed articles in academic journals. At the hearing, Dr.Mansfield testified that he began consulting for the Board in 1995, and that his objective is to provide a fair reporting assessment regarding complaint allegations.

45. Dr. Mansfield testified that MT's case was referred to him for review.

46. Dr. Mansfield outlined the standard of care, for the practice of dentistry in the State of Arizona, as follows:

a. A dentist must document a patient's treatment, including recording findings from radiographs or other images.

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[15] Director Hugunin Is the Executive Director of the Board, and has been in that position for nine years. She earned an undergraduate degree in Business from Arizona State University, and a master's degree In Organizational Management from the University of Phoenix.

b. There must be an acceptable and documented justification for treatment.

c. A dentist cannot diagnose a condition based solely on a radiograph; a dentist is required to correlate radiographic findings with clinical findings and rule out other possible explanations for radiographic findings.

d. The benefit of any treatment must outweigh the associated risks.

e. A histological exam is necessary in order for a dentist to make a diagnosis.

47. Dr. Mansfield testified that he believed Respondent deviated from the standard of care, which resulted in potential and actual harm to MT.

48. Per Dr. Mansfield, he could not locate any reference to Respondent conferring with MT's referring physician regarding MT's treatment, nor could he locate any documentation whereby MT informed Respondent that she anticipated having hip surgery. Dr. Mansfield opined that Respondent's failure to make accurate and timely notations in MT's treatment file deviated from the standard of care.

49. Dr. Mansfield testified that Respondent's diagnosis of avascular necrosis during MT's initial appointment on February 17, 20151 deviated from the standard of care because a review of MT's records did not substantiate that she had any conditions that could lead to avasecular necrosis.

50. Dr. Mansfield testified that Respondent's extraction of tooth number 3 on February 17, 2015, deviated from the standard of care because there was no clinically acceptable justification for the extraction, as there was no recorded diagnosis in MT·s treatment record. Although Dr. Mansfield identified radiolucency on a CBCT image of tooth number 3, he testified that the presence of radiolucency on a radiograph was not automatically indicative of pathology or disease. Dr. Mansfield opined that extracting tooth number 3 was also improper on the basis that MT had also had two other failed root canaled teeth extracted.

51. Dr. Mansfield testified that there was no clinically acceptable justification for Respondent's exploratory surgery on the past extraction sites of teeth numbers 1,16, 17, 18, 19, 31 and 32 to obtain "biopsy samples of crystallized bone, fatty tissue and blood" as there was no

diagnosis or justification recorded in MT's treatment records. Per Dr. Mansfield, MT's CBCT scans did not reflect infection, abnormal bone, or dead or unhealthy bone.

52. Dr. Mansfield testified that Dental DNA analysis is no substitute for histological examination, and that Respondent's failure to send the "biopsy samples" he took from MT out for a histological examination was a deviation of the standard of care. Per Dr. Mansfield, there was no indication in MT's treatment records that she ever waived or refused a histological exam of her biopsied samples. Moreover, there was no indication in MT's treatment records that Respondent ever reviewed the results of MT's Dental DNA analysis with her.

53. Per Dr. Mansfield, Respondent deviated from the standard of care by inappropriately billing MT for alveoloplasties on teeth numbers 1, 3, 16, 17, 18, 19, 31, and 32 that he believed Respondent did not perform. Additionally, Dr. Mansfield believed that Respondent unnecessarily performed a bone graft in the extraction site of tooth numbers 3 and 19, which MT was billed $450.00 for.

54. Dr. Mansfield testified that he could not discern a clinical basis for Respondent's extraction of tooth number 3, nor could he substantiate Respondent's rationale for the surgical procedures in the areas of teeth numbers 1, 16, 17, 18, 19, 31, and 32 based on Respondent's records for the patient.

55. Dr. Mansfield identified several instances whereby MT suffered actual harm as a result of Respondent's treatment. Per Dr. Mansfield, MT paid for treatments she did not receive, she left Respondent's practice with one less tooth than she presented with originally, and MT's treatment records do not establish that she benefited in any way from Respondent's treatments. Dr. Mansfield noted that even though MT presented to Respondent for alternative treatment, Respondent was nonetheless required to adhere to the established standard of care throughout her treatment.

Dr. Evan's testimony

56. Dr. Evans is a general dentist. Dr. Evans has an undergraduate degree from Texas Tech and a dental degree from Baylor College of Dentistry.

57. Dr. Evans testified that MT's case was referred to him for review.

58. Dr. Evans testified that he treated patients in his practice for ischemic bone disease, and has utilized a Cavitat to assist in his identification of low bone density. Dr. Evans further testified that he routinely diagnosis ischemic bone disease by reviewing a CBCT, as he is able to observe evidence of radiolucencies consistent with necrotic bone tissue.

59. Per Dr. Evans, "only twenty-percent" of patients diagnosed with ischemic bone disease presented to his practice with facial pain.

60. Dr. Evans testified that he saw evidence of necrotic and unhealthy bone consistent with ischemic bone disease in MT in all of the areas treated by Respondent.

61. Dr. Evans testified that he observed radiolucency and bone density in MT's extraction sites. He did not think those areas were sufficient to maintain the internal structure to support the area.

62. Dr. Evans testified that the bone Respondent removed in MT was significantly compromised.

63. Per Dr. Evans, Respondent's description of the removed bone as fat and crystallized in the MT's treatment notes is consistent with a pattern of ischemic bone.

Dr. Thomas' testimony

64. Dr. Thomas is a general dentist and a grading member of the MISCH International Implant Institute. He also serves as a clinical reviewer for the Florida Dental Board. Dr. Thomas earned his dental degree from the University of Missouri. Dr. Thomas served as the chairman of the Florida Board of Dentistry in 2009, 2014, and 2017.

65. Dr. Thomas testified that MT's case was referred to him for review.

66. Dr. Thomas testified that root canaled teeth are in a constant state of infection and are never truly asymptomatic or free of infection.

67. Dr. Thomas testified that he observed radiolucencies consistent with ischemic bone in all of the areas Respondent treated for MT.

68. Dr. Thomas testified that he believed Respondent's charting "equals or exceeds what I would have done in a similar situation as a general dentist, and it would exceed what we would

call the level of what we could define in Florida." Dr. Thomas testified that he is not aware of any standard of care which dictates that a general dentist is required to articulate radiographic findings in a patient's treatment notes because "the radiograph speaks for itself."

Respondent's testimony

69. Respondent testified that around 1997 he transitioned from traditional dentistry to what is known as holistic or biological dentistry[16]. Per Respondent, the primary difference between holistic and traditional dentistry practices is the approach of dentists in treating their patients. Respondent testified that a traditional dentist treats symptoms in teeth and gums when they become problems, and also attempt to prevent such problems from reoccurring, but that holistic dentists engage in the practice of treating underlying problems that cause symptoms in the mouth, and attempt to eliminate those problems by preventing the adverse effect on overall health patient. According to Respondent, holistic dentist work with one or more of a patient's other healthcare professionals to treat their entire being, not just a symptom or illness located in their teeth.

70. Respondent testified that based on his research he believes that there is a scientific basis for ischemic bone disease, and that the disease may be diagnosed and treated with the use of a CBCT and Cavitat.

71. Respondent testified that when MT presented to him initially she reported that she was scheduled for hip replacement surgery (although this is not documented in MT's treatment records) and had concerns regarding amalgams in her mouth.

72. Respondent testified that he radiographically confirmed the presence of ischemic bone in MT during his initial examination of her. Immediately following the exam Respondent reviewed MT's diagnostic information with her as well as a treatment plan he had devised. Although Respondent advised MT that she "may seek a second opinion from another dentist of oral surgery or treatment elsewhere," MT signed-off on her treatment plan.

[16] Dentistry licenses issued by the Board are general, and do not distinguish between traditional and holistic practices. All dentists licensed for practice in Arizona, whether traditional or holistic, were trained in the same methods in dental school and are required to operate under the same standard of care.

73. Respondent testified that he determined extraction was appropriate for tooth number 3 based on MT's Cavitat results, her CBCT scan, and his oral examination of the patient which all showed MT had necrotic tissue and low bone density in the site.

74. Respondent testified that for every tooth site he proposed treatment for, he had radiographic proof from the Cavitat of ischemic necrotic bone. Specifically, Respondent noted that in tooth site number 1 the unhealthy bone was "easy to see," for teeth site numbers 16, 17, 18, and 19 he could see "unhealed" and unhealthy bone, and for teeth site numbers 31 and 32 he could see the presence of ischemic bone. Respondent testified that cleaning out the sites and placing bone grafts were the correct course of treatment, which he did.

75. Respondent testified that the Board has never published or adopted a rule requiring practitioners to place a specific description of radiographic findings in a patient's chart. Respondent opined that MT's subsequent provider could review his treatment notes and see what how he was treating her and why.

76. Respondent testified that he believed his billing of MT was as appropriate as the CDT Code Manual allowed, because code 7550 did not exist during his treatment of MT, so he used code 7321 as it was the most applicable. Respondent denied performing unnecessary procedures as he found "some good bone, but there was some bad bone, so I took out the bad bone."

77. Respondent denied admitting operating outside of the standard of care by employing the use of a disclaimer. Respondent testified that instead he was attempting to educate his patients about varying opinions within the field of general dentistry, and to advise his patients that they may consult a traditional dentist outside the field of biological dentistry. Respondent argued that he practiced "above and beyond the standard of care" because "I go further."

78. Respondent denied causing any actual harm to MT.

CASE No. 201600123: TK's CASE

Dr. Harris' testimony

1. Dr. Harris is an oral surgeon who specializes in Maxillofacial surgery. He is thrice published and has worked in the dentistry field for approximately nineteen years[17]. At the hearing, Dr. Harris testified that he intermittently serves an independent consultant for the Board, and that TK's case was referred to him for review.

2. Dr. Harris outlined the standard of care, for the practice of dentistry in the State of Arizona, as follows:

f. A dentist must document a patient's treatment, including recording findings from radiographs or other images.

g. There must be an acceptable and documented justification for treatment.

h. A dentist cannot diagnose a condition based solely on a radiograph; a dentist is required to correlate radiographic findings with clinical findings and rule out other possible explanations for radiographic findings.

i. The benefit of any treatment must outweigh the associated risks.

j. A dentist is required to inform a patient of alternative treatment options and the risks and benefits associated with the treatment and document the review in the patient's records.

k. A histological exam is necessary in order for a dentist to make a diagnosis.

3. Dr. Harris testified that he believed Respondent deviated from the standard of care, which resulted in potential and actual harm to TK.

4. Dr. Harris testified that he could not discern a clinical basis for Respondent's removal of TK's two crowns, nor could he substantiate Respondent's rationale for the treatment based on Respondent's records for the patient.

5. Dr. Harris further opined that Respondent's removal of four of TK's teeth, which had previously all undergone successful root canals and were asymptomatic when she presented for treatment, also deviated from the standard of care as he could not identify a clinical justification for the extractions.

[17] See Board Exhibit 2.

6. Dr. Harris testified that there was no clinically acceptable justification for Respondent's exploratory surgery of teeth numbers 1, 16, 17, and 32, as all four teeth were unremarkable and completely healed where the wisdom teeth had been extracted years prior. Dr. Harris also noted that TK's periodontal ligament was vascular and would not prevent her body from creating new bone in that area.

7. Dr. Harris testified that Dental DNA analysis and histological examinations are not synonymous, and that Respondent should have sent the "biopsy samples" he took from TK out for a histological examination. There was no indication in TK's treatment records that she ever waived or refused a histological exam of her biopsied samples. Moreover, there was no indication in TK's treatment records that Respondent ever reviewed the results of TK's Dental DNA analysis with her.

8. Dr. Harris also testified that there was no clinically acceptable justification for the removal of TK's implant at tooth number 31, and that it was a deviation from the standard of care to remove the implant as it appeared "healthy, happy, and restorable." Dr. Harris noted that there was no note in TK1s treatment record to suggest that she requested the implant be removed.

9. Per Dr. Harris, Respondent inappropriately billed TK for biopsies that Respondent did not perform. Additionally, Respondent billed TK for core build-ups on teeth numbers 2 and 3 that were admittedly not performed. Respondent also charged TK for a crown for tooth number 18 that Respondent did not seat. Moreover, Respondent charged TK for alveoplasties for teeth numbers 1, 14, 15, 16, 17, 18, 19, 31, and 32, at $450.00 per tooth, which were not performed. Dr. Harris opined that Respondent's alveoplasty charges for teeth numbers 14, 15, 18, and 19 were particularly inappropriate as the procedure is a part of tooth extraction.

10. Dr. Harris noted that Respondent's use of a disclaimer for treatment was problematic in the sense that a dentist's duty to treat a patient within the standard of care cannot be absolved with a signed waiver.

11. Regarding the implants Respondent placed at teeth numbers 14, 15, 18, 15 and 19, Dr. Harris testified that Respondent's treatment deviated from the standard of care because Respondent

only fit tooth number 19 with a crown, and Respondent placed the remaining three implants angled too close together which resulted in teeth numbers15 and 18 becoming non-restorable. Additionally, Dr. Harris testified that Respondent's placement of the implants deviated from the standard of care because there was insufficient vascular bone surrounding the implants in the areas of 18 and 19, Respondent placed the nos. 18 and 19 implants within two millimeters from the inferior alveolar nerve canal (creating a risk for permanent numbness), and Respondent perforated the lingual cortex when he placed the no. 19 implant. Dr. Harris's testimony was consistent with the findings of two independent dentists who examined TK and who both found the implants non-restorable.

12. Dr. Harris identified several instanced whereby TK suffered actual harm as a result of Respondent's treatment. Per Dr. Harris, TK paid nearly $6,000.00 for treatments and a crown she did not receive, she left Respondent's practice with fewer teeth than she presented with originally, and has less functional bone in three of four quadrants than when she originally presented to Respondent. Dr. Harris opined that TK would suffer a costly expense to correct the work Respondent performed.

Dr. Evan's testimony

13. Dr. Evans testified that TK's case was referred to him for review.

14. Dr. Evans testified that he saw evidence of necrotic and unhealthy bone consistent with ischemic bone disease in TK in all of the areas treated by Respondent. Specifically, Dr. Evans testified that the Cavitat confirmed "decreased bone density" In the area surrounding tooth number 1, and evidence of radiolucency in tooth number 32. Dr. Evans noted that the surrounding bone around the site had "no internal structure." Additionally, Dr. Evans testified that he saw radiolucency along the lower left side behind the site of tooth number 17, and that there was sufficient clinical justification for Respondent to recommend a curettage in the area.

15. Dr. Evans testified that he observed radiolucency and bone density in TK's extraction sites. He did not think those areas were sufficient to maintain the internal structure to support the area.

16. Dr. Evans testified that the bone Respondent removed in TK was significantly compromised.

17. Dr. Evans testified that he did not take issue with the quality of Respondent's bone grafts.

18. Dr. Evans testified that Respondent had a clinical justification to warrant the removal of the implant for tooth 31 because he observed evidence of a radiolucency on the back side of the implant.

19. Dr. Evans testified that he saw radiographic proof-to clinically substantiate the removal of all four of the root canaled teeth. Superficially, he observed radiolucency around the apex of tooth number 14 as well as the inner radicular bone. Dr. Evans opined that the dark image in the radiolucency behind tooth number 14 indicated that there was a high probability of chronic infection. Dr. Evans agreed that Respondent's recommendation to remove tooth number 14 was correct. With respect to tooth number 15, Dr. Evans testified that is a deteriorating degenerative diseased bone."

20. Dr. Evans testified that he supported Respondent's decision to extract teeth numbers 18 and 19 because he observed radiolucency around and between the teeth on the CBCT. Per Dr. Evans, Respondent's description of the removed bone as fat and crystallized in the TK's treatment notes is consistent with a pattern of ischemic bone.

21. Dr. Evans testified that even when a root canal tooth is not painful, there could be other systemic issues going on in the absence of pain that may warrant removal of a said tooth, such as chronic degenerative pain in other areas of the body or other inflammatory processes.

22. Dr. Evans testified that a histological examination of a biopsy sample would tell the practitioner what was in the sample at a cellular level, but would not tell the clinician how the sample became infected or why. Per Dr. Evans, a DNA analysis would be useful in trying to treat the overall condition of the patient and determining the causative issues at play within the biopsied sample.

23. Dr. Evans testified that the standard of care is to obtain a histological examination based upon the judgment of the clinician as to what additional analysis may be required on a tissue sample. Dr. Evans opined that in obtaining a DNA analysis of the tissue samples removed from both patients, Respondent met the appropriate standard of care.

24. Dr. Evans also testified that the patients' records were "more than adequate records for me." Dr. Evans specifically noted that if either patient were ever to come to him directly for treatment from Respondent, Dr. Evans would be able to "pick up exactly where [he] had left off and finish the treatment." Dr. Evans believed that there was sufficient information in the treatment notes for him to carry on the treatment Respondent started.

25. Dr. Evans testified that Respondent's disclaimer simply stated that there is a difference of professional opinion within the dental community about the treatment of ischemic bone, removal of root canal teeth, and removal of metal fillings. "[The disclaimer] is not stating at all that there is a difference in the standard of care, quality of care, or any of that." Dr. Evans testified that the use of a disclaimer was simply to provide "a different perspective" about issues within the dental community on the topics outlined in the disclaimer.

Dr. Thomas' testimony

26. Dr. Thomas testified that TK's case was referred to him for review.

27. Dr. Thomas testified that he observed radiographic evidence of necrotic bone in all of the root canaled teeth sites that Respondent treated in TK.

28. Dr. Thomas testified that there was sufficient space and vascular bone between the upper and lower implants Respondent placed in TK. Dr. Thomas further testified that there was sufficient vascular bone between the upper and lower implants Respondent placed to support a crown or bridge device. Dr. Thomas noted that there is no specific rule that requires a minimum of 2 millimeters of distance between implants, but that the average width of an implant is at least 3 millimeters across and closer to 4 millimeters at the abutment of the implant.

29. Dr. Thomas testified that there is not a standard of care which is specifically related to the perforation of a lingual cortex. Per Dr. Thomas, nature teeth routinely perforate and grow

through the lingual cortex or the buckle plate, and there are times where implants are specifically placed through the area in order to provide greater stabilization for the implant device through a process known as "bicortical stabilization."

30. Dr. Thomas testified that there is no specific standard of care with respect to the distance between an implant and a patient's nerve canal. Instead, the standard of care is to avoid impinging on the nerve canal. Dr. Thomas further testified that because the practitioner is operating in a three-dimensional environment, a practitioner may go behind the nerve or around the nerve but stilt not come within a dangerous proximity, which would not be a violation of the standard of care.

31. Dr. Thomas testified that he had no concern about Respondent's placement of TK's lower implants in relation to her nerve canal. Per Dr. Thomas, it is not a violation of the standard of care for a practitioner to try and maximize the amount of bone to stabilize the implant by coming in close proximity to the nerve. It is only a standard of care violation if the practitioner hits the nerve or causes nerve damage.

32. Dr. Thomas opined that both of TK's implants were "totally restorable." Per Dr. Thomas, both sets of implants were parallel, so much so that you could "run a railroad train right down there." Dr. Thomas also opined that a crown or some sort of other restorative device could be placed on the upper and lower implants Respondent placed.

33. Dr. Thomas testified that teeth are not naturally always parallel or straight, and that although root structures grow in various directions, they still provide sufficient support for occlusion and daily chewing of food.

34. Dr. Thomas testified that Respondent's chart notes for TK clearly indicate that he performed a sinus lift. Dr. Thomas opined that Respondent's placement, of one or two millimeters of additional grafting material to create additional space, was the preferred method when placing an implant.

35. Dr. Thomas opined that Respondent's post-treatment handling and contact with TK was appropriate because Respondent appropriately followed up through indirect contact with TK's referring physician.

Respondent's testimony

36. Respondent testified that he radiographically confirmed the presence of ischemic bone in TK during his initial examination of her. Immediately following the exam Respondent reviewed TK's diagnostic information with her as well as a treatment plan he had devised. Although Respondent advised TK that she "may seek a second opinion from another dentist of oral surgery or treatment elsewhere," or do nothing, TK signed-off on her treatment plan, despite Respondent discussing alternative treatments with her for ninety-minutes[18].

37. Respondent testified that he appropriately and justifiably treated TK's crowns seated at teeth numbers 2 and 3. Per Respondent, during his initial examination he noted discoloration around the tissue of the teeth consistent with "galvanic charges." Respondent testified that TK wanted the crowns removed as a part of her desire to use non-metal restorative materials.

38. Respondent testified that for every tooth site he proposed treatment for, he had radiographic proof from the Cavitat of ischemic necrotic bone. Specifically, Respondent noted that in tooth site number 1 the bone was "poor quality" and "unhealthy." For tooth site number 32 Respondent noted that there was a long area of necrotic bone that approached the back side of the implants on 31. For tooth site number 16 Respondent noted that there was no quality bone present, citing that the bone present was low density. For tooth site 17 Respondent noted that the bone was low density and there was evidence of radiolucency. Respondent testified that he confirmed his diagnosis when he accessed the third molar sites and found a lesion containing fatty tissues, thick blood, and crystalized bone.

39. Respondent testified that he determined extraction was appropriate for teeth numbers 14, 15, 18, and 19 based on TK's Cavitat results, her CBCT scan, and his oral examination of the patient which all showed TK had necrotic tissue, low bone density in the site, and ischemic bone.

[18] Respondent later admitted that NICO was not the appropriate diagnosis for TK.

Per Respondent, there was an abscess at the root of tooth number 14, and radiolucencies between teeth numbers 18 and 19.

40. Respondent testified that he removed the implant at tooth site number 31 because it was surrounded by necrotic and unhealthy bone which he believed would fail, eventually. Per Respondent, when he began the clean-out of tooth site number 32 he discovered "mushy, necrotic bone." Respondent testified that as he approached the back side of the implant on tooth number 31, the bone was very unhealthy and started to fall away from the back side of the implant, exposing the screws of the implant in the surgical space[19]. Respondent testified that because the back part of the bone was insufficient to support the implant, he believed the probability of success for the implant on tooth number 31 was limited.

41. Regarding the implants Respondent placed for TK at teeth numbers 14, 15, 18, and 19, Respondent testified that had sufficient space between the implants and sufficient vascular bone around the implants. Respondent noted that even if the implants had been placed too close to one another, because he used a zirconium implant he could adjust the distances between the implants to create additional space if necessary. Respondent opined that TK suffered post-treatment complications because gingiva round the implant placed at tooth number 18 did not heal properly and overgrew it[20].

42. Respondent admitted that he perforated the outside of TK's lingual cortex, but testified that it was accidental and of no consequence. Respondent denied violating the standard of care. Respondent testified he believed going through the lingual cortex actually stabilized the implant, and TK made no complaints of pain related to the implant going into the lingual cortex.

43. Respondent testified that he did not violate the standard of care by working within the proximity of TK's inferior alveolar nerve canal. Respondent testified that he believed a

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[19] Respondent's testimony directly conflicts with TK's treatment records.

[20] In his ANSWER Respondent does not explicitly state that he deviated from, or fell below, the standard of care, but his position on the issue of the Implants he placed are noticeably different. In his ANSWER Respondent notes that he took education courses after his treatment of TK ended and learned better placement techniques. Respondent concludes by conceding he issued monies to TK on top of what his malpractice insurance paid out to her because he recognized the gravity of his error(s} regarding the care he provided.

practitioner's experience and training dictate how far apart the nerve canal and implant should be. Per Respondent, the standard of care is to avoid harm to the patient and to work to place the implant in such a way that it does not impinge or cause issues with the nerve canal. Respondent opined that the implants he placed were "stable, workable, and viable."

44. Respondent opined that TK's subsequent provider could review his treatment notes and see what how he was treating her and why. Respondent testified that his treatment records for TK contain information regarding her diagnosis, her treatment plan, her health history, and her clinical examinations as required by statute. Respondent testified that the Board has never published or adopted a rule requiring practitioners to place a specific description of radiographic findings in a patient's chart.

45. Respondent testified that he believed his billing for alveoloplasties were as appropriate as the CDT Code Manual allowed, because code 7550 did not exist during his treatment of TK, so he used code 7321 as it was the most applicable. Respondent denied performing unnecessary procedures as he found "some good bone, but there was some bad bone, so I took out the bad bone." Respondent testified further that he billed TK for the crown on tooth number 18 because he believed she was going to return for treatment, but later refunded her the fee. Respondent admitted that TK was charged for core build-ups on teeth numbers 2 and 3 that were not performed, but insisted he had intended to do them as part of her treatment. Per Respondent, those monies were refunded as well.

46. Respondent denied violating the standard of care by utilizing a Dental DNA analysis in lieu of a histological examination. Respondent testified that a practitioner has the discretion to use their clinical judgment to determine what type of examination to employ for a biopsy, and that the standard of care does not require that a histological examination of all tissue samples collected from a patient. Respondent further testified that based on his twenty-plus years of treating ischemic bone disease, he does not need to obtain a histological examination of a biopsy in order to confirm the presence of the disease. Per Respondent, a histological examination will not indicate prospectively how a cellular sample became the way it is, but a DNA analysis will.

47. Respondent denied admitting operating outside of the standard of care by employing the use of a disclaimer. Respondent testified that instead he was attempting to educate his patients about varying opinions within the field of general dentistry, and to advise his patients that they may consult a traditional dentist outside the field of biological dentistry. Respondent argued that he practiced "above and beyond the standard of care " because "I go further."

48. Respondent testified that he believes his relationship with TK began to deteriorate when she was late for her appointment on October 19, 2015. TK had expressed concerns regarding her implants prior to that day, and Respondent had to surgically cut back the overgrowth of gingiva around tooth number 18, he did his best to address her concerns regarding food-trapping issues she was experiencing with the crown placed at tooth number 19. Respondent testified that he also placed a crown on the implant located at tooth site number 14. Respondent testified that TK was upset prior to leaving, but he believed he had sufficiently calmed her before her departure. Respondent testified that he was surprised when TK abruptly stopped reporting for treatment, and even more surprised that she did not return any of his phone calls. Per Respondent, TK's referring physician instructed him not to contact TK and let her reach back out to him when she was ready. This discussion was not noted in TK's treatment records. Respondent testified that he wanted each patient, TK included, to "[G]et their money's worth. I want them to have health. I want to get everything right ... It doesn't always go that way, and I was sorry I could not communicate with this patient to make everything better, because I know I could've."

EXPERT WITNESS TESTIMONY

Dr. Bouquot's testimony

49. Dr. Bouquot is an oral pathologist and a general dentist who has served as the head of oral pathology departments at the University of West Virginia and the University of Texas School of Dentistry. Dr. Bouquot has published books, textbooks, and articles on maxillofacial pathology. For the past thirty or so years Dr. Bouquet has studied ischemic bone disease, also known as

neuralgia-inducing cavitational osteonecrosis ("NICO"), avascular necrosis, and ischemic osteonecrosis.

50. Dr. Bouquot testified that ischemic bone disease may be present in multiple sites throughout the human body, but that it is usually found at the end of bones where blood flow is difficult to get to - namely the jaw. Per Dr. Bouquot, ischemic bone disease in the jaw occurs when healthy bone becomes necrotic, brittle, crystallized, and hollowed out. Dr. Bouquet referred to these as "cavitations."

51. Dr. Bouquet opined that a dentist could treat and diagnose ischemic bone disease by identifying a specifically-defined radiolucency on a 30 radiograph. Dr. Bouquet testified that he believed unhealthy bone density could be measured using a Cavitat alone.

52. Dr. Bouquet testified that neuralgia and pain are not present in many patients because pain only develops in the end stages of the condition when the bone is severely compromised, and many patients present to their dentist in earlier stages of the disease.

53. Dr. Bouquot opined that the only way to remove unhealthy bone and to treat ischemic bone disease is to clean out the unhealthy bone through a surgical process known as "curettage."

Dr. Haley's testimony

54. Dr. Haley was head of the chemistry department at the University of Kentucky for approximately twenty years. He has a PhD in chemistry and biochemistry.

55. Dr. Haley testified that ischemic bone disease occurs where toxins are released into tissue surrounding a root canal, or from organic material left in the extraction site. Per Dr. Haley, every tooth subject to a root canal that he tested was always positive for some level of toxins.

56. Dr. Haley testified that because a root canaled tooth is not a self-enclosed structure, toxins can freely move from the inside of the tooth to the surrounding jaw bone creating an environment for the development of ischemic bone and necrotic bone disease.

Dr. Levy's testimony

57. Dr. Levy is a medical doctor who is board certified in internal medicine and cardiology. Dr. Levy received his medical degree from Tulane University School of Medicine and received his law degree from University of Colorado Law School.

58. Dr. Levy testified that endodontically treated teeth are infected, toxic, and have a negative effect on the overall health of a patient.

59. Dr. Levy testified that a tooth can be pain free, with no outward signs of localized infection, but still be a source of toxins and potential chronic infection that leads to systemic health challenges for the patient.

60. Dr. Levy testified that "[W]hether it's dentistry or medicine, standards of care are not fixed. They evolve. They change over time. And they shouldn't crush the dentists or the physicians who are helping to change those standards of care over time."

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case.

2. The Board bears the burden of proof to establish that Respondent committed unprofessional conduct that furnishes cause to discipline his license to practice dentistry in the State of Arizona by a preponderance of the evidence[21]. Respondent bears the burden to establish affirmative defenses and factors in mitigation of the penalty by the same evidentiary standard[22].

3. "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not"[23]. A preponderance of the evidence is "evidence which is of greater weight or more convincing than evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not."[24]

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[21] See A.R.S. § 41-1092.07(G}(1); A.A.C. R2-19-119(A} and (8)(1}; see also Vazanno v. Superior Court, 74 Ariz. 369,372,249 P.2d 837 {1952).

[22] See A.A.C. R2-19-119{B}(2).

[23] MORRIS K. UDALL, ARIZONA LAW OF EVIDENCE § 5 (1960).

[24] BLACK'S LAW DICTIONARY 1120 (8th ed. 2004).

4. Pursuant to ARIZ. REV. STAT. § 32-1201(13) "disciplinary action" means regulatory sanctions that are imposed by the board in combination with, or as an alternative to, revocation or suspension of a license and that may include:

(a) Imposition of an administrative penalty in an amount not to exceed two thousand dollars for each violation of this chapter or rules adopted under this chapter.

(b) Imposition of restrictions on the scope of practice.

(c) Imposition of peer review and professional education requirements.

(d) Imposition of censure or probation requirements best adapted to protect the public welfare, which may include a requirement for restitution to the patient resulting from violations of this chapter or rules adopted under this chapter.

5. ARIZ. REV. STAT. §32-1263.01(A) provides that the Board may take any one or a combination of the following disciplinary actions against any person licensed under the chapter:

(1) Revocation of license to practice.

(2) Suspension of license to practice.

(3) Entering a decree of censure, which may require that restitution be made to an aggrieved party.

(4) Issuance of an order fixing a period and terms of probation best adapted to protect the public health and safety and to rehabilitate the licensed person. The order fixing a period and terms of probation may require that restitution be made to the aggrieved party.

(5) Imposition of an administrative penalty in an amount not to exceed two thousand dollars for each violation of this chapter or rules adopted under this chapter.

(6) Imposition of a requirement for restitution of fees to the aggrieved party.

(7) Imposition of restrictions on the scope of practice.

(8) Imposition of peer review and professional education requirements.

(9) Imposition of community service.

6. Pursuant to Ariz. REV. STAT. § 32-1263(A)(1) the Board may impose disciplinary action against a dentist for any unprofessional conduct as defined in section 32-1201.01.

7. Pursuant to ARIZ. REV. STAT. § 32-1201.01(4) "unprofessional conduct" includes committing gross malpractice or repeated acts which constitute malpractice.

8. Pursuant to ARIZ. Rev. STAT. § 32-1201.01(14) "unprofessional conduct" includes committing any conduct or practice that constitutes a danger to the health, welfare or safety of the patient or the public.

9. Pursuant to ARIZ. REV. STAT. § 32-1201.01(16) "unprofessional conduct" includes committing repeated irregularities in billing.

10. Pursuant to ARIZ. REV. STAT. § 32-1201.01(24) "unprofessional conduct" includes failing or refusing to maintain adequate patient records.

11. ARIZ. Rev. STAT. § 32-1263(A)(4) holds that the board may invoke disciplinary action against any person who is licensed under the chapter for committing or aiding, directly or indirectly, a violation of or noncompliance with any provision of the chapter or of any rules adopted by the board.

12. ARIZ. REV. STAT. § 32-1264(A) holds that a person who is licensed or certified pursuant to the chapter shall make and maintain legible written records concerning all diagnoses, evaluations and treatments of each patient of record. It further holds that a licensee or certificate holder shall maintain records that are stored or produced electronically in retrievable paper form, including:

1. All treatment notes, including current health history and clinical examinations.

2. Prescription and dispensing information, including all drugs, medicaments and dental materials used for patient care.

3. Diagnosis and treatment planning.

4. Dental and periodontal charting. Specialist charting must include areas requested care and notation of visual oral examination describing any areas of potential pathology or radiographic irregularities.

5. All radiographs.

13. The weight of the evidence presented has established by a preponderance of the evidence that the State of Arizona holds all dentists licensed by the Board to the same standard of care. Holistic and traditional dentist alike must apprise themselves of, and be held responsible to the State's Dental Practice Act.

14. That being said, most if not all of the expert testimony offered in these matters directly conflicted with that of his adversary. The adjudicative function of this tribunal is not to validate or condemn holistic dentistry, nor is it to determine the validity of diagnostic method, nor is it to affirm the validity of a medical diagnosis. The issue in both cases is very straightforward. The tribunal is tasked with determining whether Respondent deviated from the standard of care, based on the evidence presented, and if so, whether Respondent caused potential or actual harm to a patient as a result.

15. Regarding Case No. 201700164 (MT's Case), the Board established by a preponderance of the evidence that the some of the conduct and circumstances described in the foregoing factual analysis constituted unprofessional conduct as defined in Ariz. Rev. STAT. § 32-12.01.01(14), 32-12.01.01(16), 32-1201.01(24) and a violation of A.R.S. § 32-1264 (A). Therefore, the Board has established grounds to discipline Respondent's dental license pursuant to ARIZ. REV. STAT. § § 32-1263(A)(1) and 32-1263(A)(4).

16. The record in MT's case reflects that respondent deviated from the standard of care in several instances, but said conduct did not result in actual harm to the patient. Specifically, Respondent's treatment records for MT were inadequate[25]. There are

[25] It Is clear from Respondent's testimony that he did not note the basis for his diagnosis, rationale for treatment, physician communication(s), or discussions with the patient adequately. Many of the Board's allegations regarding Respondent's treatment of the patient may have been alleviated had his charting

numerous examples whereby Respondent's notes do not include MT's current health history, recordings of interactions with her referring physician, recorded findings from radiographs, and complete treatment planning; including clinical justifications for alveoplasties, exploratory surgery, the bone graft, and the tooth extraction. Respondent's treatment notes are unclear on their face and appear to be missing information. Additionally, Respondent's failure to refer MT's biopsy samples for histological examination was also a deviation from the standard of care. Finally, Respondent's charges for alveoloplasties did not accurately reflect the procedures he actually performed.

17. The Board also failed to establish by a preponderance of the evidence that Respondent's use of a waiver or disclaimer violated the standard of care. The document in question speaks for itself. Nowhere on its face does it explicitly state or imply that the signing patient grants Respondent impunity from negligence or grants him permission to operate outside the scope of the standard of care. The Board also failed to establish by a preponderance of the evidence that Respondent did not have a clinical justifications for the extraction he performed. The Board also failed to establish by a preponderance of the evidence that MT suffered any actual harm as a result of Respondent's treatment(s) and/or practice(s).

18. Regarding Case No. 201600123 (TK's Case), the Board established by a preponderance of the evidence that the some of the conduct and circumstances described in the foregoing factual analysis constituted unprofessional conduct as defined in ARIZ. REV. STAT. § 32-12.01.01(14), 32-12.01.01(16), 32-1201(13), 32 1201.01(24), 32-1264(A). Therefore, the Board has established grounds to discipline Respondent's dental license pursuant to ARIZ. REV. STAT. § § 32-1263(A)(1) and 32 | 1263(A)(4).

19. The record in TK's case reflects that Respondent deviated from the standard of care in several instances, and said conduct resulted in actual harm to the patient.

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contained more detailed and specific Information.

Specifically, Respondent's treatment records for TK were inadequate. There are numerous examples whereby Respondent's notes do not include TK's current health history, recordings of interactions with her referring physician, recorded findings from radiographs, and complete treatment planning; including clinical justifications for alveoplasties, exploratory surgery, the bone graft, the teeth extractions, the placement of implants, and the setting of crowns. Respondent's treatment notes are unclear on their face and appear to be missing information. Additionally, Respondent's failure to refer TK's biopsy samples for histological examination was also a deviation from the standard of care. Respondent's failure to timely engage TK in post-treatment communications was also a deviation of the standard of care[26]. Respondent's placement of TK's implants was below the standard of care. Finally, Respondent's charges for alveoloplasties did not accurately reflect the procedures he actually performed on TK, Respondent charged TK for core build-ups on teeth nos. 2 and 3 which he did not do, and he charged TK for a crown on tooth no. 18 which he did not seat. The Board established by a preponderance of the evidence that TK suffered actual harm as a result of Respondent's practices as she was overcharged on multiple occasions, and her lingual cortex was perforated unintentionally.

20. The Board failed to establish by a preponderance of the evidence that Respondent's use of a waiver or disclaimer violated the standard of care. The document in question speaks for itself. Nowhere on its face does it explicitly state or imply that the signing patient grants Respondent impunity from negligence or grants him permission to operate outside the scope of the standard of care. The Board also failed to establish by a preponderance of the evidence that Respondent did not have clinical justifications for the extractions he performed, the implants he placed, and the crowns he set.

[26] That duty may not be delegated to a treating physician outside the practitioner's practice, but may be delegated to subordinate staff.

21. There was a potential for harm to both TK and MT as a result of Respondent's inadequate treatment records. Treatment records with insufficient information regarding a patient's treatment could affect the patient's continuity of care.

22. Weighing the gravity of Respondent's above-captioned conduct against the Board's interest in protecting the public, and taking into account Respondent's apparent willingness to be regulated, educated, trained, and monitored, the undersigned Administrative Law Judge hereby holds that Respondent's license shall be disciplined, but not revoked.

ORDER

Based on the Board's adoption of the Findings of Fact and Conclusions of Law, the Board issues its order that Respondent's license be placed on probation for two years, subject to the following terms:

1. **AUDITS**

a. Within thirty (30) days from the effective date of this agreement, Respondent shall engage the services of a Board-approved auditor to conduct quarterly audits of twenty (20) of the Respondent's patient records to ensure that Respondent has taken corrective action to cure the deficiencies found by the Board, including but not limited to, recording clinical justifications and diagnoses supporting treatment (including recording radiographic findings) and complete treatment planning. Additionally, the auditor will monitor whether Respondent is practicing within the standard of care with respect to sending biopsy specimens for histological examinations. Upon completion of each quarterly audit, Respondent shall ensure that the auditor submits a report to the Board with the results of the audit. The reports shall be received by the Board within 30 days from completion of each quarterly audit. Respondent shall also ensure that the appropriate measures are taken to allow the auditor access to the patient records. Respondent is responsible for all costs associated with his compliance with this provision.

b. In the event an audit report identifies continuing deficiencies in Respondent's patient records and/or failure to send biopsy specimens for histological examination or

non-compliance by Respondent with any of the terms of this Order, the Board may take further disciplinary action against Respondent, after providing Respondent notice and an opportunity to be heard.

2. **CONTINUING EDUCATION**

Within six months of the effective date of the final order, Respondent shall be required to provide to the Board acceptable written proof that he has completed eight hours of continuing education in Implantology. Respondent's failure to timely provide the Board with proof of completion regarding the above-captioned hours of education instruction shall result in the suspension of Respondent's license.

Home study or online courses are not acceptable unless they are on the list of Board approved courses that do not require prior approval. At least ten business days prior to the date of the continuing education course (s), Respondent shall obtain pre-approval for the continuing education from the Board's Executive Director. Within five days of completion of each continuing education course, Respondent shall submit to the Board verification of completion of the course(s). Verification shall be by canceled checks, attendance slips, if any, and/or a certificate of completion. The continuing education ordered is in addition to the continuing education hours required for license renewal.

It is further ordered that the effective date of this Decision and Order is the date that is signed by Board's Executive Director.

NOTICE OF APPEAL RIGHTS

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board within thirty (30) days after service of this Order. A.R.S. §41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-11-1701 (C). Service of this Order is effective on the date of personal delivery or five days after the date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty (30) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

DATED this 5th day of February, 2019

ARIZONA STATE BOARD OF DENTAL EXAMINERS

By: _____
Ryan P. Edmonson, Executive Director

Original Decision and Order
filed this 5th day of February,2019 with the:

Office of Administrative Hearings
1740 West Adams Street, Suite 2470
Phoenix, Arizona 85007

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5th day of February, 2019 to:

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