IN THE MATTER OF	*	**BEFORE THE MARYLAND**
HARRY SNYDMAN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 10340	*	**Case Number: 2015-160**

* * * * * * * * * * * * *

CONSENT ORDER

On or about March 6, 2019, the Maryland State Board of Dental Examiners (the "Board") charged **HARRY SNYDMAN, D.D.S.** (the "Respondent"), License Number 10340, under the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. & 2018 Supp.) and Md. Code Regs. ("COMAR") 10.44.30 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. § 4-315 and COMAR 10.44.30 *et seq.*:

> **Health Occ. § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.**
>
> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may . . . reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the . . . licensee:
>
> . . . .
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> . . . .
>
> (20) Violates any rule or regulation adopted by the Board[.]

COMAR 10.44.30.02. General Provisions for Handwritten, Typed and Electronic Health Records.

. . . .

B. Dental records shall include:

(1) A patient's clinical chart as described in Regulation .03 of this chapter; and

. . . .

K. Dental records shall:

. . . .

(2) Be detailed;

(3) Be legible;

. . . .

(5) Document all data in the dentist's possession pertaining to the patient's dental health status;

L. Entries shall be signed or initialed by the individual who provided the treatment.

. . . .

U. Dentists are responsible for the content of the dental records.

COMAR 10.44.30.03. Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

. . . .

(5) Diagnosis and treatment notes; [and]

. . . .

(15) Informed consent[.]

COMAR 10.44.30.05. Violations.

Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On April 17, 2019, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following:

I. BACKGROUND

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about March 22, 1990, under License Number 10340. The Respondent's license is current through June 30, 2020.

2. At all times relevant, the Respondent practiced general dentistry at a dental practice in Owings Mills, Maryland.

3. The Board initiated an investigation of the Respondent after receiving a complaint, on or about March 17, 2015, from a patient ("Patient A"), who alleged that she developed atypical trigeminal neuralgia and two abscesses after receiving dental treatment by the Respondent.[1]

[1] Upon review of the Respondent's dental chart for Patient A, the Expert opined that due to the lack of patient symptoms proximal to the planning and delivery of the # 15 crown, it was reasonable for the Respondent not to order or perform additional diagnostic testing.

II. BOARD INVESTIGATION

4. In the course of its investigation, the Board subpoenaed Patient A's dental chart and five additional patient dental charts from the Respondent and submitted them to a licensed dentist (the "Board Expert") for an expert review. Based on his review, the Board Expert determined that the Respondent exhibited a pattern of deficiencies in his recordkeeping practices.

A. Summary of Deficiencies

5. The Respondent's recordkeeping practices with respect to Patients A through F were deficient for reasons including:

a) Failing to document informed consent;

b) Failing to document diagnostic testing or diagnoses for endodontic treatment provided;

c) Failing to document legible notes;[2] and

d) Failing to document tooth isolation with a rubber dam for the root canal treatments ("RCTs") performed.

B. Patient-Specific Allegations

Patient A

6. Patient A, then in her mid-30s, initially saw the Respondent in June 2000. Patient A received routine dental care until she presented with a broken DL[3] cusp on Tooth #14 on September 12, 2005. Patient A reported that she was not in pain at that

[2] Notably, according to the Board's Expert, the handwriting was so "illegible" that it "made interpretation of doctor notes almost impossible." Therefore, the Board had to issue a second request to the Respondent for typed chart notes for the patients.

[3] The five tooth surfaces are: D=Distal, O=Occlusal, B=Buccal, M=Mesial and L=Lingual.

time. A buildup and a crown were placed on Tooth #14 on September 29, 2005. Patient A subsequently reported experiencing discomfort on or about October 12, 2005; however, the examination and the pulp testing did not indicate a pulpal problem.

7. Patient A returned to the Respondent's practice sporadically for routine dental examinations, prophylaxis, and small restorations until 2014. On or about January 28, 2014, Patient A presented with a fractured Tooth #15. A radiograph was taken, and a buildup and crown was placed on Tooth #15.

8. Then, Patient A was seen for the last time by the Respondent on March 12, 2014, for a routine dental recall, at which time, nothing significant was noted.

9. The Respondent's recordkeeping practices with respect to Patient A were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes; and

c) Failing to document adequate clinical examination in detail.

Patient B

10. Patient B, then in her mid-40s, initially presented to the Respondent on or about February 20, 2013. From February 20, 2013 until March 30, 2015, Patient B received extensive dental care including seven RCTs, restorations and crowns. The seven RCTs were: Tooth #12 on April 10, 2013; Tooth #19 between April 24, 2013, and June 19, 2013; Tooth #21 between April 7, 2014, and April 22, 2014; Teeth #3 and #5 between July 22, 2014, and August 12, 2014; and Teeth #10 and #11 between March 9, 2015, and March 30, 2015.

11. While performing the seven RCTs, the Respondent failed to document the use of a rubber dam to isolate the teeth.

12. The Respondent's recordkeeping practices with respect to Patient B were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes;

c) Failing to document clinical details to include diagnostic testing and diagnoses; and

d) Failing to document the use of rubber dam for tooth isolation during RCT.

Patient C

13. Patient C, then in his mid-30s, initially presented to the Respondent in October 2013. From October 3, 2013 until November 12, 2015, Patient C received extensive dental care including three RCTs, multiple restorations, and prophylaxis. The three RCTs were: Tooth #3 on November 7, 2013; Tooth #14 on January 23, 2014; and Tooth #11 on March 4, 2014.

14. While performing the three RCTs, the Respondent failed to document the use of a rubber dam to isolate the teeth.

15. The Respondent's recordkeeping practices with respect to Patient C were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes;

c) Failing to document clinical details to include diagnostic testing and diagnoses; and

d) Failing to document the use of rubber dam for tooth isolation during RCT.

Patient D

16. Patient D, then in his late 40s, initially saw the Respondent in April 2004. Patient D received dental services from April 2004 until approximately 2006.[4] Patient D returned to the Respondent as a new patient in December 2013. From December 17, 2013 until February 16, 2015, Patient D received dental care including seven RCTs and extensive restorative work. The seven RCTs were: Teeth #4 and #5 on January 13, 2014; Tooth #31 on January 15, 2014; Tooth #11 on January 23, 2014; Tooth #20 on February 6, 2014; Tooth #2 on April 29, 2014; and Tooth #12 on September 15, 2014.

17. While performing the seven RCTs, the Respondent failed to document the use of a rubber dam to isolate the teeth.

18. The Respondent's recordkeeping practices with respect to Patient D were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes;

c) Failing to document clinical details to include diagnostic testing and diagnoses; and

d) Failing to document the use of rubber dam for tooth isolation during RCT.

[4] The Respondent failed to provide the Board with a copy of Patient D's medical record from 2004 to 2006, however, pursuant to Md. Code Ann., Health Gen. § 4-403(b) (2014 Repl. Vol. & 2018 Supp.), a dental provider is entitled to destroy a patient's medical records after five years.

Patient E

19. Patient E, then in her late 20s, initially presented to the Respondent in January 2013. From January 24, 2013 until December 23, 2015, Patient E received dental care from the Respondent including three RCTs and extensive restorative work. The three RCTs were: Tooth #13 on October 19, 2013; Tooth #15 on February 19, 2014; and Tooth #21 on May 22, 2014.

20. While performing the three RCTs, the Respondent failed to document the use of a rubber dam to isolate the teeth.

21. The Respondent's recordkeeping practices with respect to Patient E were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes;

c) Failing to document clinical details to include diagnostic testing and diagnoses; and

d) Failing to document the use of rubber dam for tooth isolation during RCT.

Patient F

22. Patient F, then in her early 30, initially saw the Respondent in July 2005. From July 13, 2005 until December 22, 2014, Patient F received dental care from the Respondent including one RCT on Tooth #18 on March 19, 2014, and routine prophylaxis.

23. While performing RCT on Tooth #18 on March 19, 2014, the Respondent failed to document the use of a rubber dam for tooth isolation.

24. The Respondent's recordkeeping practices with respect to Patient F were deficient for reasons including:

a) Failing to include written informed consent;

b) Failing to document legible notes;

c) Failing to document clinical details to include diagnostic testing and diagnoses; and

d) Failing to document the use of rubber dam for tooth isolation during RCT.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the following provisions of the Act: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.30 *et seq.*, in violation of Health Occ. § 4-315(a)(20).

ORDER

Based on the foregoing findings of fact and conclusions of law, it is, by a majority of the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS, commencing on the date of the Consent Order**, and continuing until the Respondent successfully completes the following conditions:

1. **Within six (6) months**, the Respondent shall enroll in and successfully complete a Board-approved course in recordkeeping consisting of four (4) credit hours. The Respondent may not use the coursework to fulfill any requirements mandated for license renewal. The Respondent shall submit written verification that satisfied the Board of the successful completion of the course within 30 days of completion of the course;

2. The Board, in its discretion, during the probationary period, may conduct chart reviews of dental treatments the Respondent provided after his completion of the recordkeeping course for compliance with the Maryland Dentistry Act and the Board's regulations.

3. **Within sixty (60) days** of the date of this Consent Order, the Respondent shall pay a fine in the amount of **ONE THOUSAND FIVE HUNDRED DOLLARS** ($1,500.00) payable to the Maryland State Board of Dental Examiners.

4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining to the practice of dentistry.

AND IT IS FURTHER ORDERED that no part of the training or education that the Respondent receives in connection with this Consent Order may be applied to his required continuing education credits; and it is further

ORDERED that at the conclusion of the eighteen (18) month probationary period, the Respondent may petition the Board for a termination of his probation. The Board will terminate the Respondent's probation as long as he has fulfilled all of the terms and conditions of the Consent Order, and that there are no pending complaints of similar violations; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, after notice and an opportunity for an evidentiary hearing if

there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing otherwise, may impose any sanction, including additional probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).

5/01/19
Date

Francis X. McLaughlin
Executive Director
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Harry Snydman, D.D.S., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue

and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having consulted with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order and understand its effect.

4/29/19
Date

Harry Snydman, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 29 day of April, 2019, before me, a Notary Public of the State and City/County aforesaid, personally appeared Harry Snydman, D.D.S., and declared and affirmed under the penalties of perjury that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESS my hand and Notarial seal.

Melissa J. Cosner
Notary Public

My Commission expires: 06-27-2019