IN THE MATTER OF	*	**BEFORE THE**
HAMID RYAN KAZEMI, D.M.D.	*	**STATE BOARD OF DENTAL**
LICENSE NO. 11793	*	**EXAMINERS**
RESPONDENT	*	**Case Nos. 2009-101**

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FINAL ORDER

Procedural Background

On October 28, 2008, the Maryland State Board of Dental Examiners (the "Board") received a complaint about Hamid R. Kazemi, D.M.D. ("the Respondent"), and on January 13, 2009, the Respondent was sent a letter notifying him of the complaint with a Subpoena Duces Tecum for Patient A's[1] records. On January 16, 2009, the Respondent mailed a response to the Board along with the requested records. On July 21, 2009, the Board issued a subpoena to the Respondent for an interview to occur on September 22, 2009. On September 22, 2009 the Respondent was interviewed. On September 7, 2010, Respondent was sent a letter giving him notice of the Charges under the Maryland Dentistry Act ("Charges") and notice of the evidentiary hearing about the Charges scheduled for January 19, 2011. On January 19, 2011, the Board held an evidentiary hearing before a quorum of the Board, in accordance with Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-201 *et seq.*, and the regulations adopted by the Board at Code of Md. Regs tit. ("COMAR") 10.44.07.

[1] The identity of the patient is not disclosed to protect the confidentiality of the patient's medical record.

SUMMARY OF THE EVIDENCE

A. Documents

The following documents were admitted into evidence.

State's Exhibit No. 1 - Charges under Maryland Dental Practice Act, 9/7/2010

State's Exhibit No. 2 - Investigative Report, 6/11/2009, with documents attached:

a. Complaint, 10/28/2008
b. Subpoena to Astrid Noguera, DRT, 6/11/2009, with license information
c. Subpoena to Respondent, 7/21/2009, license information, Transcript of Interview, 9/22/2009
d. Subpoena to Respondent for patients records, 1/13/2009; with records, pp. 000001 – 0000037
e. Letter to Respondent, 1/13/2009, and Respondent's response to complaint, 1/16/2009
f. Subpoena, 1/13/2009, and records from Dr. Funari

Respondent's Exhibit No. 1 - Patient A's vital signs chart from 3/7/2008

Respondent's Exhibit No. 2 - CV of Daniel I. Fried, D.M.D.

A. Witness Testimony

State's Witnesses:

Kevin Schwartz, D.M.D., Expert Witness in Oral Surgery
Mr. A, Father of Patient A
Ms. A, Mother of Patient A
Astrid Alleana Noguera, surgical technician

Respondent's Witnesses:

Hamid R. Kazemi, D.M.D.
Daniel Fried, D.M.D.

BACKGROUND AND SUMMARY

At all times relevant, the Respondent, an oral surgeon, was licensed by the Board and owned and operated a solo dental practice. The charges arose after the Board received a complaint from a father of a twelve-year old girl at the time who was a patient of the Respondent. The Respondent saw Patient A upon referral from her orthodontist. The Respondent was to perform extractions of her molars, so that Patient's A's orthodontist could proceed with her treatment.

There was an initial visit in which the mother and Patient A came to see the Respondent in January of 2008 and the surgery was planned for early March of 2008. Patient A presented March 7th, 2008 with her father for the planned extractions. As it turned out, the surgical procedure was a little more difficult and time consuming than The Respondent had anticipated in terms of extracting one of Patient A's teeth. The entire procedure took longer than he anticipated, and also necessitated additional anesthesia, and anesthesia over a longer period of time.

When the procedure was finished Patient A was taken to the recovery room. Patient A's father became concerned about his daughter's condition. Patient A did not look well and was not alert. Over the course of the afternoon, the family learned that the Respondent was not in the office, and he had left the office. The Respondent testified that he went to the airport to take an international flight to see his ailing mother.

The Respondent stated that Patient A could have been discharged before he left the office, but he wanted to be "nice" and allow her recovery in his office. The Respondent's statements on Patient A's condition were inconsistent with his actions. If the Respondent really felt that Patient A could be discharged, then he should have sent

her home when he left the office. Instead, Patient A was left to be monitored by unqualified auxiliary personnel. Only a dentist can monitor a patient recovering from the anesthesia.

FINDINGS OF FACT

Based upon a review of the documentary and testimonial evidence admitted into the administrative record of this matter, the Board finds the following:

1. At all times relevant hereto, the Respondent was licensed to practice in Maryland. The Respondent was first licensed as a dentist on June 22, 1995 . The Respondent's license for dentistry expired on June 30, 2009. The Respondent was granted a permit for General Anesthesia Administration on April 2, 1997, to expire on April 1, 2010. The Respondent was further licensed in oral and maxillofacial surgery beginning August 8, 1995.

2. At all times relevant hereto, and since February 1997, Respondent started, owned, and operated his practice as a solo practitioner at 4825 Bethesda Avenue, Suite 310, Bethesda, Maryland.

3. While employed as a dentist and oral surgeon, the Respondent evaluated, recommended surgery, and performed surgery on Patient A.

4. On January 21, 2008, Patient A, then a twelve-year-old child, initially presented with the Mother to the Respondent for a surgical consultation. Patient A's Orthodontist had recommended the removal of the lower 3rd molars, surgical uprighting of the lower left 2nd molar, and exposure of tooth # 18 and the attachment of a bracket and chain. The Respondent recommended the removal of

all four of the 3rd molars, in addition to the other recommended work. The Respondent subsequently informed Board staff that he made this decision so the Patient A would not have to have a second surgery in the future to remove the upper 3rd molars.

5. During this initial office visit on January 21, 2008, the Respondent discussed the procedure and the anesthesia that would be used with Patient A's mother. The Respondent recommended having the procedure done on a Friday so that Patient A would have the weekend to recover and be able to return to school on Monday.

6. Patient A's mother agreed to have the procedure performed and signed informed consent forms for the procedure and the general anesthesia.

7. On Friday, March 7, 2008, at approximately 8:00 a.m., Patient returned to the Respondent for the previously discussed procedure, this time accompanied by her father.

8. The Respondent began the procedure at approximately 8:30 a.m. Patient A's father stated that approximately 45 minutes into the procedure, the Respondent came out from the operatory to inform him that there was a complication with the removal of one of the molars.

9. Patient A's father further stated that at approximately 10:30 a.m. the Respondent came out from the operatory a second time to tell him that the molar had been removed successfully. The Respondent also told Patient A's father that he could not see his daughter because the complication required the use of additional anesthesia and that Patient A was still under the effect of the anesthesia.

10. According to the Respondent's dental records, the Patient A had been given the following anesthesia by the time the surgery was completed: Fentanyl 150 mg, IV Valium 17.5 mg, Brevital 70 mg, Decadron 4 mg, Droperidol 2.5 mg, and continuous inhalation of 50/50 oxygen and nitrous oxide.

11. Patient A's Father stated that he was finally allowed to see his daughter at 11:30 a.m. Patient A was groggy, sleepy and unable to respond to her name except with gestures. At this time, the Patient A's father was informed by a member of the office staff that there had been some the complications in his daughter's surgery. He was informed that her sinus cavity had been broken and that she had received additional anesthesia during the procedure.

12. At approximately 2:00 p.m., Patient A's father began to receive calls from his wife who asked questions about Patient A's recovery from the procedure. At this time, the Father asked if he could speak to the Respondent. An office staff member called the Respondent and instructed the father to speak to the Respondent on the telephone. The father stated he had not been aware the Respondent was no longer present in the office.

13. The Respondent stated that he left the office around 2:30 p.m. in order to catch an international flight and that when he left the office, the "surgical assistant" and "front desk people" were still present to monitor the Patient A. According to Patient A's Father, the office staff monitored Patient A's recovery and encouraged her to drink fluids throughout her stay at the Respondent's office. None of the individuals present in the office were qualified or permitted to monitor Patient A without the Respondent.

14. According to both Patient A's mother and father, the office staff continued to monitor her until approximately 3:00 p.m., when Patient A's mother arrived at the Respondent's office. Her mother also asked to speak to the Respondent. The office staff again called the Respondent and told Patient A's mother she could speak to the Respondent on the telephone.

15. At approximately 5:00 p.m., the office staff informed Patient A's mother and father that they would have to take her home because they were closing the office for the night. Patient A's family was told that she would be fine at home. They were loaned a pulse monitoring device to take home to check her pulse. According to the Patient A's parents, when the Patient left the office, she was still groggy and mostly asleep, and unable to walk on her own. When the Patient reached the parking lot of the Respondent's office, she vomited the fluids she had been given throughout the course of the day. At that time, Patient A was also bleeding from her nose.

16. When Patient A arrived at home that evening, she was still unable to walk unassisted and had to be carried to the bathroom until the following Sunday, nearly two full days after she was first administered anesthesia by the Respondent. Patient A was unable to return to school for a week.

17. According to the Respondent's dental records, the Respondent wrote a prescription for Penicillin and Tylenol #3 to be taken following the surgery.

18. On Saturday, March 8, 2008, the day after the surgery, the Respondent, while abroad, called Patient A's parents to check on her recovery and to

remind the parents to schedule a follow-up appointment. The Respondent instructed the Mother to continue giving Patient A Tylenol #3.

19. On Sunday, March 9, 2008, Patient A's mother, concerned that Patient A A was still sleeping, on the suggestion of a physician friend, discontinued Tylenol #3 and instead gave over-the-counter Tylenol to the Patient. After the switch, Patient A became more alert.

20. The Respondent failed to clearly explain that he was leaving the office while Patient A's parents had the understanding that she was still in a doctor's care.

21. Patient A was still in need of care after respondent left the office. This is evidenced by Respondent's continued contact with the office about Patient A's condition and the fact that she was not discharged.

22. The Respondent failed to have adequate action plan for coverage by another doctor in the event Respondent needed to leave when a patient is still in need of a doctor's supervision. After the Respondent left, there was no other dentist present to monitor Patient A.

23. The Respondent failed to leave Patient A in the charge of another doctor's care when Patient was not yet definitely ready to leave.

CONCLUSIONS OF LAW

"Administrative actions under the [Maryland Medical Practice Act] are intended to 'provide the Board with sufficient authority to assure a high standard of medical care from physicians licensed in this State.'" *Pickert v. Maryland Board of Physicians,* 180 Md. App. 490, 505 (2008), quoting, *Solomon v. Bd. of Physician Quality Assurance,* 132 Md. App. 447, 455 (2000). The unprofessional conduct of the Respondent warranted

the Board taking public action against the Respondent. The public must be able to trust that a dentist will be competent and ethical in the provision of dental services. This is especially true of an oral and maxillofacial surgeon who has unconscious and semi-conscious patients who are susceptible to more severe risks and complications than patients of basic dental procedures. The respondent violated the public's trust by leaving his offices before a minor patient recovered from a surgical procedure without his or any other dentist's presence. The Respondent failed to communicate his assessment of the patient in light of his departure to the Patient A's parents. The respondent's thoughtless actions were an abuse of his position of trust as a healthcare professional.

The Respondent failed to act professionally and behaved dishonorably, in violation of section 4-315(a)(16) of the Health Occupations Article. The Board finds the testimony of the State's expert, Kevin Schwartz, D.D.S., oral surgeon, convincing. Dr. Schwartz explained that the Respondent acted unprofessionally when he left the office and left Patient A before she was fully recovered and able to be discharged in a safe manner. (Tr., at 49.) The Respondent also left Patient A in the care of people who were unqualified to monitor the patient during the postoperative recovery period.

Daniel Fried, D.M.D., an oral surgeon, testified as an expert witness for the Respondent. Dr. Fried testified that Patient A was stable and ready for discharge at the time the Respondent left. (Tr., at 245-46.) Dr. Fried explained that monitoring Patient A until the office closed was not necessary, but rather was "a measure of kindness." (Tr., at 246 and 248) Therefore, the Respondent had no duty to stay and monitor Patient A.

The Board does not find Dr. Fried's analysis persuasive. The Board does not believe that Dr. Fried's model would assure a professional and honorable conduct.

The Board believes that the Respondent failed to comply with the standards of professional conduct and the American Dental Association Principles of Ethics and Code of Professional Conduct. Although Respondent has expressed remorse for his actions, the Board must address his misconduct and redress the harm caused by the Respondent to the victim, the public, and the dental profession.

Based upon the foregoing findings of fact and opinion, the Board concludes that the Respondent is subject to discipline. The Respondent violated H.O. § 4 315 (a)(16) (behaved dishonorably or unprofessionally) in regard to Patient A, including, but not limited to the fact that he:

a. Scheduled a potentially complicated surgical procedure in the morning on the same day that he had to leave his office at mid-day for an international flight;

b. Failed to inform Patient A's father that he was leaving the office before the she was fully recovered from the effects of deep IV anesthesia;

c. Left the office before the Patient A had stable vital signs, was ambulatory with assistance and stable enough to be discharged;

d. Delegated the care of Patient A to a DRT and "front desk people" while Patient A was still under the effects of deep IV anesthesia, when the DRT and "front desk people" were not qualified to undertake the Respondent's duties;

e Failed to have back-up coverage with another dentist to come to his office to monitor Patient A's recovery when he left the office; and

f. Allowed Patient A to be discharged before she was fully

recovered from the effects of deep IV anesthesia.

For all of these reasons, the Board finds that The Respondent violated H.O. § 4-315(a)(16).

The Board also finds that The Respondent violated of a professional code of ethics. Specifically, the American Dental Association, Principles of Ethics and Code of Professional Conduct, 2.0 (use of auxiliary personnel) in regard to Patient A to whom he had administered deep IV anesthesia, including, but not limited to the fact that he: delegated the care of Patient A, which may not be delegated, to the DRT and "front desk people." These individuals were not qualified to care for Patient A during recovery without supervision. After the Respondent left the office to catch a flight, Patient A was still under the effects of deep IV anesthesia and he was not available on-site to supervise the DRT's or "front desk people's" monitoring of Patient A.

ORDER

Based on the foregoing Findings of Fact, Opinion, and Conclusions of Law, by a unanimous decision of a quorum of the Board it is hereby:

ORDERED that the Respondent be reprimanded, and be it further,

ORDERED that the Respondent complete a Board approved Ethics Course within 30 days of the date of this order, and be it further,

ORDERED that the Respondent create an action plan for coverage by a qualified individual in the event that Respondent need to leave his office while a Patient is still in his care within 30 days of the date of this order and provide proof of said plan to the Board, and be it further,

ORDERED that this is a final order of the Maryland Board of Dental Examiners and as such is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't Art., §§10-611, *et seq.*

12/21/12
Date

Ngoc Quang Chu, D.D.S.,
President, Maryland State Board
of Dental Examiners

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. Art., § 4-319(b), you have the right to take a direct judicial appeal. A petition for appeal shall be filed within thirty (30) days of your receipt of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't Art., §§10-201, *et seq.*, and Title 7, Chapter 200 of the Maryland Rules.