IN THE MATTER OF	*	**BEFORE THE MARYLAND**
AMAL RASTOGI, D.M.D.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 14431	*	**Case Number: 2012-123**

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CONSENT ORDER

On or about February 12, 2013, the Maryland State Board of Dental Examiners (the "Board") charged **AMAL RASTOGI, D.M.D.** (the "Respondent"), (D.O.B. 6/2/78) License Number 14431, under the Maryland Dentistry Act ("the Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 4-101 *et seq.* (2011 Repl. Vol & 2012 Supp.)

The pertinent provisions of the Act under H.O. § 4-315 provide the following:

(a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:

(6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;

(16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;

(20) Willfully makes or files a false report or record in the practice of dentistry; [and]

(24) Uses or promotes or causes the use of any misleading, deceiving or untruthful advertising matter, promotional literature or testimonial[.]

The Board further charged the Respondent with violating applicable COMAR regulations:

COMAR 10.44.12.04 Anxiolysis.

(C) A dentist who administers anxiolysis may not administer a dose that is inappropriate for a patient's:

(1) Age:
(2) Weight;
(3) Medical condition;
(4) Infirmities; or
(5) Other propensities.

COMAR 10.44.12.06 Permit required.

After January 4, 2010, a dentist may not administer an anesthetic technique in order to attain a level above anxiolysis[1] for the practice of dentistry unless the dentist holds an appropriate Class I, II, or III permit issued by the Board.

COMAR 10.44.12.08 (H) Class II: Moderate Parenteral Sedation Permit.

To qualify for a Class II permit, an applicant shall successfully complete:

(1) A Board-approved course of instruction that documents training of at least 60 hours of didactic instruction plus management of at least 20 patients per participant in moderate parenteral sedation techniques; or

(2) A postdoctoral training program accredited by the Commission on Dental Accreditation or its successor organization that affords comprehensive and appropriate training necessary to administer and manage moderate parenteral sedation.

[1] Anxiolysis is defined as a drug-induced state, with or without nitrous oxide/oxygen to decrease anxiety, in which patients respond normally to tactile stimulation and verbal commands. COMAR 10.44.12.03(B)(5).

COMAR 10.44.12.11 Facility Evaluation Criteria

A. To qualify for a permit, the facility and the applicant shall pass an evaluation of facility equipment, medications, and clinical records to include at least the following:

(14) Electrocardiogram (EKG), Class II and Class III permits;

(16) Defibrillator or automated external defibrillator (AED) for adult patients[.]

On or about June 5, 2013, the Respondent and the State appeared before a Case Resolution Conference Committee of the Board in order to explore a potential resolution of this matter. The Respondent agreed to enter into this Consent Order as a full and full resolution of the Charges.

FINDINGS OF FACT

The Board finds the following:

1. The Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent initially received his license on April 6, 2009. His license will expire on June 30, 2015.

2. The Respondent was and is licensed to practice dentistry in the State of Virginia, under license number 0401412038, issued on January 15, 2008.

3. At all times relevant hereto, the Respondent maintained a private practice located in Waldorf, Maryland.

4. At all times relevant, the Respondent had neither applied for nor had been issued a Class I, II or III sedation permit pursuant to COMAR 10.44.12.06. The Respondent was not authorized under the Act to administer an anesthetic technique in order to attain a level beyond anxiolysis.

I. COMPLAINT

5. On or about December 27, 2011, the Board received a letter from the Respondent reporting the death of a male patient ("Patient A") on December 13, 2011, following the administration of Morphine during a flap and osseous resective surgery.[2]

6. The Board initiated a complaint ("Board Complaint") and began an investigation. During the course of its investigation, the Board received a second complaint, dated June 15, 2012, from Patient A's widow ("Complaint 2"). Complaint 2 supplemented the information provided by the Respondent in his initial letter. The results of the Board's investigation are set forth *infra*.

II. BOARD INVESTIGATION

7. On July 20, 2011, Patient A, a 56 year old male, presented to the Respondent for a new patient consultation and examination. The Respondent noted a history of hypertension, morbid obesity, Demerol allergy, and a low pain threshold. He diagnosed Patient A with generalized severe chronic periodontitis and recommended four (4) quadrant flap and osseous surgery. The Respondent discussed with Patient A the possible anesthetic options of anxiolysis, sedation and general anesthesia, making clear that he could offer only anxiolysis because he had not been issued a sedation permit by the Board. The Respondent's records note that Patient A declined anxiolysis stating that he did not experience anxiety during dental procedures, only pain.

8. On July 21, 2011, the Respondent performed surgery of the first quadrant after administering a short-acting local anesthetic. The Respondent noted that Patient A reported no anxiety but was uncomfortable and requested additional analgesia for future procedures. Patient A requested that the Respondent administer Morphine during the next

[2] A procedure in which gum tissue is pushed away from the roots of the teeth to provide access and visualization for root planning.

procedure. Prior to discharge, the Respondent prescribed Percocet for post-operative pain relief.

9. On July 24, 2011, the Respondent refilled Patient A's prescription for Percocet noting that the "[c]linically, [Patient A] was healing remarkably well, but indicated that he was still experiencing moderate post-operative pain...."

10. On September 14, 2011, the Respondent performed surgery of the second quadrant, once again administering a short-acting local anesthetic. According to the Respondent, Patient A reported general discomfort and again requested Morphine prior to the third quadrant procedure. According to the Respondent, he informed Patient A that he could offer a local anesthetic and anxiolysis during future treatment, or could arrange for a referral if Patient A preferred sedation or general anesthesia. Patient A elected to continue treatment with the Respondent, leaving the Respondent's office with a prescription and one (1) refill for Percocet.

11. Patient A was scheduled for surgery of the third quadrant on December 13, 2011 from approximately 11:45 a.m. to 1:15 p.m. According to the Respondent, during the pre-operative discussion, Patient A requested Morphine in addition to the local anesthetic. Respondent stated that Patient A "was quite adamant that he did not consent to have any further periodontal surgery done without additional analgesia", and stated that he had tolerated "high doses [of Morphine] when passing kidney stones".

12. The Respondent informed Patient A that he did not keep Morphine in his office but agreed to utilize Morphine from his "emergency drug kit"[3]. The Respondent advised Patient A that "he did not intend to sedate him and would titrate the dose accordingly".

[3] The Respondent obtained Morphine sulfate, injectable saline and syringes from his office emergency drug kit to be used in the event that a dental patient suffered a myorcardial infarcation.

13. The Respondent failed to consider the medical risks associated with Patient A's morbid obesity (approximately 370 lbs.) and hyperlipidemia. Patient A did not report a history of respiratory problems or sleep apnea. Respondent did not inquire whether Patient A suffered from respiratory obstruction or sleep apnea nor did Respondent inquire whether Patient A was NPO[4].

14. At approximately 11:45 a.m., the Respondent injected 2.5 mg. Morphine intramuscular ("I.M.") into Patient A's left deltoid. The Respondent noted that Patient A continued to experience pain. The Respondent administered two additional 2.5 mg. doses I.M. between 12:00-12:40 p.m. bringing the total dosage to 7.5 mg. Morphine over the course of one (1) hour.

15. The Respondent concluded the procedure at approximately 1:15 p.m. According to the Respondent, Patient A was conscious, stable and breathing spontaneously. He was given a prescription and refill for Percocet for management of post-operative pain.

16. At 1:30 p.m. Patient A was permitted to leave the Respondent's office unescorted. He advised the Respondent's office staff that he wanted "fresh air" and was going to his truck to access his cell phone to call for a ride home. Neither the Respondent nor his staff took any precautions to ensure that Patient A was escorted to his truck or that he had actually arranged for a ride after the administration of Morphine.

17. Patient A was observed by Respondent's staff to be alert and awake in his truck at approximately 1:45 p.m. Shortly thereafter, Patient A fell asleep in his truck. At approximately 3:45 p.m. Respondent inquired as to the whereabouts of Patient A and was advised by his staff that he had last been observed two (2) hours earlier. Respondent went

[4] The latin term *nil per osis* is the medical instruction meaning to withhold oral food and fluids from a patient to prevent aspiration of ingested food/fluids following anesthetic sedation.

to check on Patient A and found him drowsy in his truck and escorted him back into the office.

18. The Respondent administered oxygen (2L/min), monitored vital signs and provided palliative care to Patient A.

19. At approximately 4:00 p.m., the Respondent administered 0.1 mg. of Naloxone, a reversal agent for Morphine. He administered three (3) additional doses of 0.1 mg. of Naloxone between 4:10-4:40 p.m., bringing the total dosage of Naloxone to 0.4 mg.

20. Patient A's wife was contacted at approximately 4:15 p.m. She was advised that Patient A had received "a little [m]orphine" during his dental procedure and needed to be transported home. Just prior to her arrival at approximately 4:56 p.m., Patient A experienced nausea and an episode of emesis[5], a recognized side effect of Morphine.

21. The Board's investigation revealed that upon her arrival, Patient A's wife advised the Respondent that Patient A had obstructive sleep apnea.

22. According to the Respondent, he discussed with Patient A and his wife further evaluation by the local hospital. The Respondent did not call 911 to have Patient A taken to a hospital emergency department for evaluation. The Respondent released Patient A to the care of his wife, providing her with a portable pulse oximeter and discharge instructions that included NPO status, no sleeping until at least 8 p.m., and use of Patient A's Continuous Positive Airway Pressure ("CPAP") device.

23. The Respondent observed Patient A experiencing a second episode of emesis in the office parking lot.

[5] The act of vomiting.

24. At approximately 9:30 a.m. on December 14, 2011, the Respondent called Patient A's home to check on him and was advised that Patient A had been found unresponsive with his CPAP device off and had died.

25. A subsequent post mortem examination revealed that the cause of death was "hypertensive atherosclerotic cardiovascular disease, obesity and sleep apnea complicating Morphine use during dental procedure". Toxicology reports revealed 72 mcg/L "free [M]orphine" in a sample of Patient A's blood obtained during the autopsy.

Interview of the Respondent

26. On or about October 18, 2012, the Board investigator interviewed the Respondent under oath regarding the circumstances surrounding Patient A's death. The Respondent stated as follows:

a. His website described him as "trained in oral and IV sedation";

b. He had not been issued a sedation permit by the Board;

c. He had never before administered Morphine;

d. Outside of his residency training, he had never administered Naloxone or any other reversal agent on a medicated patient;

e. He was not aware of any transportation protocol following the use of Morphine. The Respondent assumed that because Patient A was a neuropsychologist, he should have been aware that he could not drive himself home;

f. In response to Patient A's request, the Respondent determined just prior to the start of the procedure that he would administer Morphine from his emergency first aid kit;

g. Neither the Respondent nor anyone from his staff monitored Patient A's medical status from 1:30 p.m. to 3:45 p.m. when Patient A was discovered asleep in his truck;

h. His documentation was "vague" as to how long Patient A was left in his truck because [Patient A] "didn't seem to be necessarily monitored" during that time;

i. He administered oxygen, palliative care and the reversal agent, Naloxone "in an abundance of caution", not because of any medical concern following his administration of Morphine;

j. He stated to Patient A's wife that [Patient A] was responding well to the reversal agent, Naloxone. Respondent discussed with Patient A and his wife further monitoring in an emergency room but left the decision to the discretion of Patient A and his wife;

k. After learning that Patient A's wife was a nurse, he gave her a portable pulse oximeter and discharge instructions; and

l. After being told that Patient A had obstructive sleep apnea, he recommended that Patient A should use his CPAP machine that night.

Peer Review

27. During the course of its investigation, the Board requested a peer review of the Respondent's treatment of Patient A as well as thirteen (13) additional patient charts. The board certified peer reviewer, ("Board expert") provided a report to the Board dated November 7, 2012.

28. The Board expert noted that Morphine is contraindicated in patients with respiratory obstruction because of its known depression of the central nervous and respiratory systems. The Respondent failed to inquire whether Patient A suffered from obstructive sleep apnea and failed to modify his treatment plan upon learning from Patient A's wife that Patient A had been diagnosed with obstructive sleep apnea and used a CPAP machine.

29. The Board expert noted that I.M. injection of Morphine is considered a parenteral technique of administration, requiring a Board issued *Class II Moderate Parenteral Sedation Permit.* He further noted that the use of conscious sedation in a dental office

required that the patient maintain NPO status for 6-8 hours prior to the procedure, and that the Respondent ensure that a designated escort be available to transport the patient home.

30. From his review of the additional patient charts, the Board expert noted that the Respondent required pre-anesthetic fasting and *a designated transportation protocol for his* anxiolysis patients but did not require the same safeguards in his treatment of Patient A.

31. The Board expert opined that the dosage of Morphine administered by the Respondent was arbitrary and that the medical indications for administering Naloxone were "totally inadequate and inappropriate".

32. The Board expert found that the Respondent's use of Morphine and his attempt to reverse the effects utilizing Naloxone was incompetent and violated applicable COMAR regulations requiring the issuance of a sedation permit.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner in violation of H.O. § 4-315 (a)(6); behaved dishonorably or unprofessionally, or violated a professional code of behaving dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of H.O. § 4-315(a)(16); Willfully made or filed a false report or record in the practice of dentistry in violation of H.O.§ 4-315 (a)(20); and used or promoted or caused the use of any misleading, deceiving or untruthful advertising matter, promotional literature or testimonial in violation of H.O. § 4-315(a)(24).

The Board further concludes as a matter of law that the Respondent administered sedation without an appropriate permit in violation of COMAR §§ 10.44.12.04.,06,.08 and .11.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 21ST day of AUGUST 2013, by a majority of a quorum of the Board considering this case:

ORDERED that effective **September 13, 2013**, Respondent's license to practice dentistry shall be **SUSPENDED for three (3) years**, with all but **six (6) months stayed;** and it is further

ORDERED that during the six (6) month period of active suspension, the Respondent shall enroll in and successfully complete a Board approved course in dental ethics with a particular focus on patient boundaries and ethical recordkeeping requirements; and it is further

ORDERED that during the six (6) month period of active suspension, the Respondent shall enroll in and successfully complete a Board approved course in documentation; and it is further

ORDERED that the Respondent shall immediately and permanently cease and desist from administering Morphine and/or Naloxone to any patient except as may be necessary in a life threatening emergency; and it is further

ORDERED that Respondent shall immediately remove from his website or any advertising materials, references to his training "in oral and IV sedation"; and it is further

ORDERED that the Respondent shall provide to the Board documentation of all terms and conditions as specified above, prior to the Board lifting the active period of suspension; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **three (3) years,** from the date that the active suspension is lifted subject to the following terms and conditions:

1. The Respondent shall be subject to two (2) peer reviews of his practice to ensure that he is providing anxiolysis only, in doses appropriate for the patient's age, weight, medical condition and infirmities. The peer reviews shall further evaluate all aspects of Respondent's practice of dentistry and compliance with the Act including but not limited to billing, documentation, ethical requirements and standards of practice.

2. The reviewer shall be selected and designated by the Board at the request of the Respondent. The Respondent shall make a written request to the Board, to initiate the first peer review no earlier than one (1) year and no later than eighteen (18) months after the execution of the Consent Order.

3. The Respondent shall make a written request to the Board, for the second peer review no earlier than one (1) year after completion of the first peer review.

4. Upon receipt of the Respondent's written request(s), the Board shall designate a Board approved reviewer to conduct an unannounced on-site chart review of at least (5) patient charts. All aspects of the Respondent's practice shall be addressed.

5. The reviewer shall have access to the Respondent's appointment book for the purposes of selecting patient charts. Once selected, the Respondent shall provide to the reviewer a complete record, including billing, for each patient whose care is being reviewed.

6. The Respondent shall ensure that the reviewer submit written reports to the Board within thirty (30) days of each on-site review. The report shall describe the reviewer's findings and recommendations, if any.

7. The Respondent shall comply with all written recommendations of the reviewer. Failure to comply may be deemed a violation of the Consent Order;

8. The Respondent shall complete all required continuing education courses

required for renewal of his license. No part of the training or education that he receives in compliance with this Consent Order shall be applied to his required continuing education credits.

ORDERED the Respondent shall at all times comply with and practice according to the Maryland Dentistry Act and all laws and regulations pertaining to the practice of dentistry; and it is further

ORDERED the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that any violation of the terms or conditions of this Consent Order shall be deemed a violation of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before the Board or an Administrative Law Judge, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of probation being proved by a preponderance of the evidence; and it is further

ORDERED that after completion of three (3) years of probation, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination only if the Respondent has fully and satisfactorily complied with all probationary terms and conditions and there are no pending complaints or investigations related to the charges; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol. & 2012 Supp.)

8/21/2013
Date

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

CONSENT

I, Amal Rastogi, D.M.D., License No. 14431 acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I 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.[6]

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 had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and

[6] Respondent does not waive any rights he may have to contest the Findings of Fact or Conclusions of Law in any civil proceeding not involving the Board.

terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

7/30/2013
Date

Amal Rastogi, D.M.D.
Respondent

Read and approved by:

Catherine D. Steiner
Catherine Steiner, Esquire
Counsel to Respondent

NOTARY

STATE OF Maryland

~~CITY~~/COUNTY OF: Charles

I HEREBY CERTIFY that on this 30th day of July, 2013, before me, a Notary Public of the State and County aforesaid, personally appeared Amal Rastogi, D.M.D. and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Toni R. Coleman
Notary Public

My commission expires: 04/03/2015

TONI R. COLEMAN
NOTARY PUBLIC
PRINCE GEORGE'S COUNTY
MARYLAND
MY COMMISSION EXPIRES APRIL 3, 2015