LAWRENCE BELL, JR., D.D.S.
3326 Auchentoroly Terrace
Baltimore, Maryland 21217

Arthur C. Jee, D.M.D.
Board President
Maryland State Board of Dental Examiners
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21613

RE: **Permanent Surrender of Dental License**
License Number: 5628
Case Numbers: 2013-125, 2013-204,
2015-036, 2015-205, 2016-090 and 2017-181

Dear Dr. Jee and Members of the Board:

Please be advised that I have decided to **PERMANENTLY SURRENDER** my license to practice dentistry in the State of Maryland, License Number 5628, effective June 29, 2018. From the time I sign this Permanent Letter of Surrender until June 29, 2018, I agree not to practice dentistry in any form and not to be present at the clinical treatment areas of my dental practice while patient treatments are being rendered. I understand that upon the effective date of this Permanent Letter of Surrender, I may not represent myself to the public by title, by description of services, methods, procedures, or otherwise that I am licensed to practice dentistry in Maryland. Moreover, I may not practice dentistry, as it is defined in Md. Code Ann., Health Occ. I ("Health Occ. I") § 4-101(l).

I understand that upon the Board's acceptance, this Permanent Letter of Surrender becomes a **FINAL ORDER** of the Board. I understand that the permanent surrender of my license means that I am in the same position as an unlicensed individual.

My decision to permanently surrender my license to practice dentistry in Maryland was prompted in part on health considerations and in part by the Maryland State Board of Dental Examiners' (the "Board's") investigation of my license and its subsequent issuance of *Charges Under the Maryland Dentistry Act* (the "Charges"), dated July 5, 2017. **A copy of the Charges is attached hereto and incorporated herein.**

I have decided to permanently surrender my license due in part to health concerns and in part to avoid prosecution of these disciplinary charges.

I wish to state clearly that I have voluntarily, knowingly, and freely chosen to submit this Permanent Letter of Surrender. I understand that, by the execution of this Permanent Letter of Surrender, I am waiving the right to contest the Charges in a formal

evidentiary hearing at which I would have 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 provided by law, including the right to appeal.

I acknowledge that upon the effective date of this Permanent Letter of Surrender, I shall surrender to the Board my Maryland dental license, number 5628, including any wall certificate, renewal certificates and wallet-sized renewal cards in my possession. I understand that the Board will advise the National Practitioner Data Bank of this Permanent Letter of Surrender, and in any response to inquiry, that I have surrendered my license in lieu of disciplinary action under the Act as resolution of the matters pending against me. I also understand that in the event I would apply for licensure in any form in any other state or jurisdiction, that this Permanent Letter of Surrender, and all underlying documents, may be released or published by the Board to the same extent as a final order that would result from disciplinary action pursuant to Md. Code Ann., General Prov. §§ 4-101 *et seq*. (2014).

I further recognize and agree that by submitting this Permanent Letter of Surrender, my dental license in Maryland will remain permanently surrendered. In other words, I agree that I have no right to reapply for a license to practice dentistry in the State of Maryland. I further agree that the Board is not obligated to consider any application for licensure that I might file at a future date and that I waive any hearing rights that I might possess regarding any such application.

I acknowledge that I may not rescind this Permanent Letter of Surrender in part or in its entirety for any reason whatsoever. I understand the nature and effect of both the Board's actions and this Permanent Letter of Surrender fully. I acknowledge that I understand the language, meaning, terms, and effect of this Letter of Surrender. I acknowledge that I have consulted counsel before signing this Permanent Letter of Surrender and I make this decision knowingly, voluntarily and without any duress.

Sincerely yours,

3/26/18
Date

Lawrence Bell, Jr.

NOTARY PUBLIC

Jacqueline E. Roane
NOTARY PUBLIC
City of Baltimore, Maryland
My Commission Expires 10/28/2021

STATE OF Maryland

CITY/COUNTY OF Balto City

I HEREBY CERTIFY that on this 26 day of March, 2018, before me, a Notary Public of the State and City/County aforesaid, personally appear Lawrence Bell, Jr., and declared and affirmed under the penalties of perjury that signing the foregoing Permanent Letter of Surrender was his voluntary act and deed.

AS WITNESS my hand and Notarial seal.

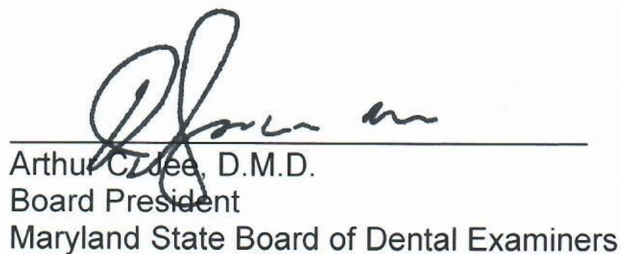
Jacqueline E. Roane
NOTARY PUBLIC
City of Baltimore, Maryland
My Commission Expires 10/28/2021

Notary Public

My Commission expires: 10/28/21

ACCEPTANCE

On this 4th day of April, 2018, I, Arthur C. Jee, D.M.D., on behalf of the Maryland State Board of Dental Examiners, accept Lawrence Bell, Jr.'s **PUBLIC PERMANENT SURRENDER** of his license to practice dentistry in the State of Maryland.



Arthur C. Jee, D.M.D.
Board President
Maryland State Board of Dental Examiners

IN THE MATTER OF	*	BEFORE THE MARYLAND
LAWRENCE BELL, JR., D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 5628	*	Case Numbers: 2013-125 2013-204 2015-036 2015-205 2016-090

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CHARGES UNDER THE MARYLAND DENTISTRY ACT

The Maryland State Board of Dental Examiners (the "Board") hereby charges **LAWRENCE BELL, JR., D.D.S.** (the "Respondent"), License Number 5628, under the Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. I ("Health Occ. I") §§ 4-101 *et seq.* (2014 Repl. Vol.).

Specifically, The Board charges the Respondent with violating the following provisions of the Act and Md. Code Regs. ("COMAR"):

Health Occ. I § 315. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

(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, a limited license to practice dentistry, or a teacher's license to practice dentistry to any applicant, reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:

(1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another;

(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) Violates any rule or regulation adopted by the Board;

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

(34) Willfully and without legal justification, fails to cooperate with a lawful investigation conducted by the Board.

COMAR 10.44.23.01. Unprofessional or Dishonorable Conduct.

B. A dentist, dental hygienist, or dental radiation technologist may not engage in unprofessional or dishonorable conduct.

C. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry, dental hygiene, or dental radiation technology:

. . .

(2) Engage in conduct which is unbecoming a member of the dental profession; [and]

. . .

(7) Willfully and without legal justification, failing to cooperate with a lawful investigation conducted by the Board, which include, but is not limited to:

(a) Furnishing information requested;

(b) Complying with a subpoena; [and]

. . .

(d) Providing meaningful and timely access to relevant patient records; [and]

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry, dental hygiene, or dental radiation technology.

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

I. A dental record shall contain:

. . .

(7) Medical and dental histories which shall be updated at each visit[.]

K. Dental records shall:

(1) Be accurate;

(2) Be detailed; [and]

. . .

(4) Document all data in the dentist's possession pertaining to the patient's dental health status[.]

COMAR 10.44.30.03 Clinical Charts.

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

. . .

(4) Patient's complaints;

(5) Diagnosis and treatment notes;

(6) Progress notes;

(7) Post operative instructions;

. . .

(11) Clinical details with regard to the administration of:

(a) Nitrous oxide;

(b) Anxiolytics;

(c) Sedation; and

(d) General anesthesia.

. . .

(13) Periodontal charting; [and]

. . .

(20) Noncompliance and missed appointment notes[.]

COMAR 10.44.30.05. Violations.

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

ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that it has reason to believe are true:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on June 4, 1997, under License Number 5628. The Respondent's license is current through June 30, 2018.

2. At all times relevant, the Respondent maintained an office for the practice of dentistry in Baltimore, Maryland.

II. PRIOR DISCIPLINARY HISTORY

A. Case Numbers 2001-084 and 2001-245

3. On or about July 11, 2001, the Board charged the Respondent under Board Case Numbers 2001-084 and 2001-245 with violating various provisions of the Act based on allegations that the Respondent: provided substandard preoperative and postoperative care to a patient after a surgical extraction; and failed to provide an accurate response to a question in his 1998 dental renewal application.

[1] The allegations set forth in these charges are intended to provide the Respondent with notice of the Board's action. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

4. The Respondent resolved the Board's charges by entering into a Consent Order, dated September 5, 2001, in which the Board found as a matter of law that the Respondent: fraudulently or deceptively attempted to obtain a license, in violation of Md. Code Ann., Health Occ. § 4-315(a)(1)(2000 Repl. Vol.); practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of § 4-315(a)(6); behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of § 4-315(a)(16); and willfully made or filed a false report or record in the practice of dentistry, in violation of § 4-315(a)(20).

5. Pursuant to the Consent Order, the Board suspended the Respondent's dental license for a period of thirty (30) days, which was immediately stayed, and placed him on probation for a period of three (3) years, subject to certain terms and conditions, including, but not limited to, making an anonymous donation in the amount of Two Thousand Five Hundred Dollars ($2,500.00) to the Maryland Foundation for Dentistry for the Handicapped and completing continuing education courses in oral surgery and ethics.

B. Case Number 2005-070

6. On or about February 5, 2005, the Board charged the Respondent under Board Case Number 2005-070 with violating various provisions of the Act based on allegations that he failed to respond to a patient's request for her dental record and failed to respond to a Board-issued subpoena.

7. On or about September 7, 2005, the Board held an evidentiary hearing on the merits at the Respondent's request. On December 12, 2005, the Board issued its

Findings of Fact, Opinion, Conclusions of Law and Order, in which it concluded that the Respondent behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of Md. Code Ann., Health Occ. § 4-315(a)(16)(2000 Repl. Vol.); failed to comply with any Board order, in violation of § 4-315(a)(31); and failed to comply with Md. Code Ann., Health Gen. § 4-304.

8. Pursuant to the Board's final order, it suspended the Respondent's dental license for a period of thirty (30) days; ordered that he take and pass the Jurisprudence, Ethics, and Risk Management Examination offered by the Northeast Regional Board; imposed a fine in the amount of One Thousand Two Hundred and Fifty Dollars ($1,250.00); and placed him on probation for a period of three (3) years.

III. CURRENT COMPLAINTS

A. Case Number 2013-125

9. On or about January 8, 2013, the Board received a complaint from a patient ("Patient A")[2] of the Respondent who alleged that the Respondent: placed a poorly performed crown in her mouth; billed insurance company for an additional crown, which she never received; and billed insurance company for a root canal therapy which was never performed. After receiving the complaint, the Board initiated an investigation of the Respondent under Case Number 2013-125.

B. Case Number 2013-204

10. On or about April 19, 2013, the Maryland Health Care Alternative Dispute Resolution Office notified the Board of a health claim filed against the Respondent by

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[2] To ensure confidentiality and privacy, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this document. The Respondent may obtain the identity of the referenced individuals or entities in this document by contacting the administrative prosecutor.

one of his patients ("Patient B"). In the health claim, Patient B alleged that the Respondent breached applicable standards of care when he failed to diagnose Patient B with sinus exposures during molar extractions; failed to inform Patient B prior to the extractions of the risk of sinus exposures; failed to perform proper post-extraction follow-up with Patient B; and failed to refer Patient B to an oral surgeon. After receiving the complaint, the Board initiated a second investigation of the Respondent under Case Number 2013-204.

C. Case Number 2015-036

11. On or about September 2, 2014, the Board received another complaint against the Respondent from a patient ("Patient C") who alleged that after several visits with the Respondent for filling and filling adjustment, she continued to experience significant pain and numbness to the left side of her mouth to the extent that she could not open her mouth. Patient C later saw another dentist who diagnosed her with Temporomandibular Joint ("TMJ") pain. Patient C alleged that the TMJ was caused by the Respondent's repeated attempts to open her mouth widely when he performed filling and filling adjustments on her. After receiving the complaint, the Board initiated a third investigation of the Respondent under Case Number 2015-036.

D. Case Number 2015-205

12. On or about May 12, 2015, the Board received another complaint against the Respondent from a patient ("Patient D") who alleged that in December 2014, she saw the Respondent for several visits, during which the Respondent placed a Maryland Bridge in her mouth. Patient D alleged that as a result of the Respondent's improper treatment, her tissues and bones were damaged and the Maryland Bridge fell out after a

week. Patient D stated that the Respondent's improper treatment led to her later hospitalization. After receiving the complaint, the Board initiated a fourth investigation of the Respondent under Case Number 2015-205.

E. Case Number 2016-090

13. On or about December 1, 2015, the Board received another complaint from a patient ("Patient E") who saw the Respondent in September 2015 for extraction of a wisdom tooth. Patient E alleged that the Respondent took one hour and forty-five minutes to extract the wisdom tooth, during which he injured Patient E's lip and the side of his mouth. Patient E stated that after the extraction, he continued to experience pain and bone fragments lacerating his tongue. Patient E stated that he subsequently saw several other dentists who were unable to repair the injuries the Respondent caused. After receiving the complaint, the Board initiated a fifth investigation of the Respondent under Case Number 2016-090.

IV. BOARD INVESTIGATIONS

A. Failure to Cooperate in Case Number 2013-125

14. After receiving the complaint in Case Number 2013-125, the Board, on or about January 22, 2013, issued a subpoena to the Respondent for Patient A's dental records and a written response to the complaint. The Board's subpoena directed that the Respondent produce the documents by February 4, 2013.

15. The Respondent failed to produce the documents by February 4, 2013, and on or about March 5, 2013, a Board investigator sent a letter to the Respondent reiterating the Respondent's obligation to comply with the Board subpoena.

16. The Respondent did not produce to the Board Patient A's dental records and his written response to Patient A's complaint until approximately March 11, 2013.

17. On or about November 5, 2015, the Board issued a subpoena to the Respondent for his dental practice appointment book for the period from October 1, 2014, to June 30, 2015. The Board's subpoena directed the Respondent to produce the appointment book by November 20, 2015.

18. The Respondent failed to produce his appointment book to the Board by November 20, 2015, and on or about December 10, 2015, a Board staff member sent a letter to the Respondent reiterating the Respondent's obligation to comply with the Board subpoena.

19. The Respondent did not produce his appointment for the relevant time period until approximately December 17, 2015.

20. On or about February 9, 2016, the Board issued a subpoena to the Respondent for five specified patient dental records. The Board's subpoena directed the Respondent to produce the patient records by February 26, 2016.

21. As of the date of these charges, the Respondent has not produced to the Board the five patient dental records specified in the Board's subpoena.

B. Failure to Cooperate in Case Number 2013-204

22. After receiving the complaint in Case Number 2013-204, the Board, on or about May 9, 2013, issued a subpoena to the Respondent for Patient B's dental records. The Board's subpoena directed the Respondent to produce Patient B's dental records by May 20, 2013.

23. The Respondent failed to produce to the Board Patient B's dental records by May 20, 2013.

24. By letter dated November 12, 2013, a Board's investigator advised the Respondent of his obligation to comply with the Board's subpoena.

25. The Respondent did not produce to the Board Patient B's dental records until approximately November 21, 2013.

C. Failure to Cooperate in Case Number 2015-036

26. After receiving the complaint in Case Number 2015-036, the Board, on or about November 3, 2014, issued a subpoena to the Respondent for Patient C's dental records and a written response to Patient C's complaint. The Board's subpoena directed the Respondent to produce the documents by November 20, 2014.

27. The Respondent failed to produce Patient C's dental records and a written response to Patient C's complaint by November 20, 2014.

28. On or about February 2, 2015, a Board's investigator sent a letter to the Respondent reiterating his obligation to comply with the Board's earlier subpoena.

29. The Respondent did not produce Patient C's dental records and a written response to Patient C's complaint until approximately February 18, 2015.

30. On or about February 9, 2016, the Board issued a subpoena to the Respondent for four specified patient dental records. The Board's subpoena directed the Respondent to produce the patient records by February 26, 2016.

31. As of the date of these charges, the Respondent has not produced to the Board the four patient dental records specified in the Board's subpoena.

D. Failure to Cooperate in Case Number 2015-205

32. After receiving the complaint in Case Number 2015-205, the Board, on or about July 7, 2015, issued a subpoena to the Respondent for Patient D's dental records. In the cover letter to the subpoena, the Board also directed the Respondent to provide a written response to Patient D's complaint. The Board's letter and subpoena directed that the Respondent produce the documents by July 20, 2015.

33. The Respondent produced Patient D's dental records and a written response to Patient D's complaint on or about July 20, 2015.

34. On or about November 5, 2015, the Board issued a subpoena to the Respondent for his dental practice appointment book for the period from October 1, 2014, to June 30, 2015. The Board's subpoena directed the Respondent to produce the appointment book by November 20, 2015.

35. The Respondent failed to produce his appointment book to the Board by November 20, 2015, and on or about December 10, 2015, a Board staff member sent a letter to the Respondent reiterating the Respondent's obligation to comply with the Board subpoena.

36. The Respondent did not produce his appointment book for the relevant time period until on or about December 17, 2015.

E. Failure to Cooperate in Case Number 2016-090

37. After receiving the complaint in Case Number 2016-090, the Board, on or about January 15, 2016, issued a subpoena to the Respondent for Patient E's dental records. The Board's subpoena directed the Respondent to produce Patient E's dental records by February 1, 2016.

38. The Respondent failed to produce to the Board Patient E's dental records by February 1, 2016.

39. The Respondent did not produce to the Board Patient E's dental records until approximately February 26, 2016.

F. 2016 Renewal Application

40. As part of the investigations, a Board investigator reviewed the Respondent's 2016 online licensing renewal application (the "2016 Renewal"), which he filed on or about June 30, 2016. The 2016 Renewal covered the period from July 1, 2014, through June 30, 2016.

41. In the 2016 Renewal, the Respondent answered "NO" to a question under the Character and Fitness section, which asked:

> Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?

42. The Respondent willfully failed to disclose in the 2016 Renewal that he was under investigation by the Board based on five pending complaints.

G. Expert Review of Patient Records

43. In its investigation of the Respondent's clinical practices, the Board forwarded the dental records of Patients A through E to a licensed dentist (the "Expert") for an expert review. After his review, the Expert determined that the Respondent was grossly incompetent in his treatment and care of Patients A through E and failed to keep adequate dental records. Examples of these gross deficiencies are set forth in the following patient summaries.

Patient A

44. Patient A, a female born in the 1970s, initially saw the Respondent on or about August 22, 2011. Patient A had the following radiographs taken: panoramic, periapical on Teeth #8 and #9, and two bitewings. The Respondent conducted an examination and formulated a treatment plan, which included multiple restorations, dental prophylaxis and a nightguard. The Respondent failed to conduct and document a review of Patient A's medical history, head and neck examination, intraoral hard and soft tissue screening and an oral cancer screening. The Respondent also failed to conduct and document periodontal charting. In addition, the Respondent failed to document the reason he ordered a periapical radiograph of Teeth #8 and #9, as well as his findings.

45. Patient A returned on or about September 16, 2011. The Respondent documented that Patient A's chief complaint involved tooth #8 but failed to document what the complaint was, whether he performed an examination and what his findings were. The Respondent also documented that he placed a composite core and an upper impression for a temp on Tooth #8 but failed to document support for the treatment he provided. Despite documenting crown preparations for Teeth #7 and #8, the Respondent failed to document the clinical status of the teeth, the dental rationale for the necessity of the treatment, and consideration of alternative treatment such as excavation and filling restoration.

46. The Respondent scheduled Patient A to return on October 3, 2011, for insertion of the crowns but failed to document that she missed her appointment.

47. Patient A did not return to see the Respondent until on or about April 12, 2012. The Respondent documented that Patient A's chief complaints involved Teeth #7 and #8 but failed to document what the complaints were. The Respondent performed a root canal therapy ("RCT") on Tooth #8 but failed to document whether he performed an examination, the treatment necessity for the RCT and whether he used a rubber dam. Up to this date, the Respondent had not performed or documented periodontal charting.

48. The Respondent scheduled Patient A to return in one week for cementing the crowns but failed to document that she missed her appointment.

49. Patient A did not return to see the Respondent until on or about July 23, 2012. The Respondent documented inserting crowns on Teeth #7 and #8 but failed to document the clinical status of the teeth, which he prepped 10 months prior.

50. On or about December 21, 2012, Patient A saw the Respondent for a core build-up and re-cementing of the crown on Tooth #8 but failed to document the dental necessity of a core build-up.

51. Patient A returned on or about January 3, 2013, and the Respondent documented a need for post/core treatment on Tooth #8. The following day, on or about January 4, 2013, the Respondent documented placement of a post/core on Tooth #8. The Respondent used lidocaine with epinephrine but failed to document the dental necessity for the use of this anesthetic. A radiograph taken that day, which the Respondent failed document in the progress notes, showed the post was inadequate to support the crown.

52. The Respondent's dental treatment and care of Patient A were grossly deficient for reasons including, but not limited to:

A. Failing to review or document reviewing Patient A's medical history with her on each visit;

B. Failing to document Patient A's chief complaints in detail;

C. Failing to perform and/or document an intraoral examination to include hard and soft tissue examination, periodontal examination and charting, head and neck examination, and oral cancer screening;

D. Failing to document clinical support for the necessity of crowns on Teeth #7 and #8, as the radiograph for Tooth #7 showed no decay;

E. Failing to discuss and/or document discussing alternative treatment plans such as composite restoration;

F. Failing to document clinical support for performing RCT on Tooth #8;

G. Placing a post on Tooth #8 that was inadequate for retention; and

H. Failing document Patient A's missed or cancelled appointments.

Patient B

53. Patient B, a male born in the 1940s, initially saw the Respondent on or about February 24, 2012. The Respondent did not document Patient B's chief complaint for this visit. Patient B's medical history included high blood pressure,

swollen ankles, chest pain, easily winded, recent weight loss and multiple medications taken.

54. The Respondent documented extracting Teeth #2 and #14, placing sutures and prescribing an antibiotic and pain medication. The Respondent, however, failed to document an examination, a diagnosis, or reviewing Patient B's medical history. The Respondent also failed to conduct a medical consultation prior to providing treatment. The Respondent's notes concerning the surgical extractions were scant with no documentation with respect to any testing for sinus involvement, or the number and type of sutures placed. The periapical radiographs taken showed close proximity between teeth/root and sinus cavity with very thin alveolus. In addition, the Respondent failed to conduct a post-operative sinus inspection or provide and document post-operative instructions.

55. On or about March 2, 2012, the Respondent diagnosed Patient B with having a dry socket. The Respondent prescribed an antibiotic and pain medication, and scheduled Patient B to return in one week. The Respondent failed to document Patient B's chief complaint, what if any examination he performed, or his clinical findings. The Respondent failed to diagnose Patient B with oral-antral communication and failed to refer him to a specialist.

56. Patient B returned on or about March 19, 2012, and the Respondent documented that Patient B was healing within normal limits. The Respondent initiated a fabrication of a denture and scheduled Patient B to return in two weeks. The Respondent failed to document that he performed any examination and failed to diagnose Patient B with oral-antral communication.

57. Patient B subsequently saw three dental and medical specialists who diagnosed him with bilateral oral-antral opening and fistula formation, which required extensive surgical correction.

58. The Respondent's dental treatment and care of Patient B were grossly deficient for reasons including, but not limited to:

A. Failing to review or document Patient B's medical history with him at each visit;

B. Failing to document Patient B's chief complaint in detail;

C. Failing to document examinations and findings;

D. Failing to perform a medical consultation prior to rendering treatment;

E. Performing extractions of Teeth #2 and #14 without documented clinical support;

F. Failing to perform post-operative inspections and testing or provide post operative instructions; and

G. Failing to diagnose Patient B with oral-antral communication and refer him to a specialist for further care.

Patient C

59. Patient C, a female born in the 1940s, initially saw the Respondent on or about November 9, 2010. The Respondent failed to perform and/or document a detailed examination of the head, neck, and intraoral hard and soft tissue. The Respondent also failed to perform and/or document a periodontal examination, which

would be necessary to support his scheduled plan to perform quadrant scaling. The Respondent also failed to document any examination regarding TMJ.

60. At this visit, the Respondent prescribed Tylenol #3 (Acetaminophen/Codeine) and PenVK (Penicillin V potassium), but failed to document any medical necessity for these prescriptions.

61. On or about March 27, 2014, Patient C returned to the Respondent's office. On this visit, the Respondent again failed to perform and/or document any periodontal examination, despite his plan to perform quadrant scaling. The Respondent also failed to document or evaluate Patient C's TMJ. The Respondent recorded scant documentation regarding examination of hard and soft tissues and a head and neck examination.

62. On this visit, the Respondent prescribed Tylenol #3 (Acetaminophen/Codeine) and PenVK (Penicillin V potassium), but failed to document any medical necessity for these prescriptions.

63. On or about April 3, 2014, the Respondent performed two quadrants of scaling on Patient C. However, the Respondent recorded very limited documentation and failed to document a diagnosis that would support the scaling. The Respondent also failed to document any use of anesthesia and failed to document periodontal charting.

64. The next day, on or about April 4, 2014, the Respondent performed scaling on Patient C's other two quadrants. The Respondent's documentation was again scant, with no documentation of anesthesia, no record of bleeding, measurement

of attached gingival, or mobility of the teeth. The Respondent failed to document a diagnosis that would support scaling.

65. On or about April 10, 2014, the Respondent noted in Patient C's chart, "refine upper and lower mouth, prophy." This notation is too vague and fails to document what treatments were actually performed. Again, the Respondent failed to document periodontal status and TMJ status.

66. On or about May 8, 2014, the Respondent performed fillings on Teeth #17 and #18. However, the Respondent's documentation was scant, and he failed to document the depth of the decay or whether there was any pulpal involvement.

67. On or about May 13, 2014, the Respondent failed to document the status of the filling on Tooth #18, which had been performed only a few days previously.

68. On or about May 19, 2014, the Respondent polished the fillings on Teeth #17 and #18 but failed to document why the use of anesthesia was necessary to perform this procedure. The Respondent also took radiographs of fillings but failed to document a reason for the radiographs, or any other findings from them.

69. On or about May 24, 2014, the Respondent noted "NV: extract #18" (apparently recommending that Tooth #18 be extracted), but did not document a clinical diagnosis to support this treatment recommendation, or that there were any problems associated with this tooth.

70. The Respondent again prescribed Tylenol #3 (Acetaminophen/Codeine) and PenVK (Penicillin V potassium), but failed to document any medical necessity for these prescriptions.

71. Although the Respondent's chart for August 11, 2014, indicates a visit, the Respondent failed to what occurred during this visit. The Respondent's narrative response states that Patient C complained of some discomfort on this day, but it is not documented in his office note. The Respondent did not document in the prior note that he was recommending extraction of Tooth #18.

72. On or about June 5, 2014, Patient C saw another provider who diagnosed her with acute TMJ dysfunction and immediately referred her to a specialist.

73. The Respondent's dental treatment and care of Patient C were grossly deficient for reasons including, but not limited to:

A. Failing to document the necessity of prescription medications;

B. Failing to document appropriate diagnoses, examinations, and findings;

C. Failing to document appropriate justification for treatment including periodontal scaling; and

D. Recommending extraction of Tooth #18 without documented clinical support.

Patient D

74. Patient D, a female born in the 1960s, initially saw the Respondent on or about June 30, 2007. On this visit, the Respondent failed to review and/or document reviewing Patient D's medical history. The Respondent also failed to perform and/or document a head and neck examination, soft and hard tissue examination, or

periodontal examination. The Respondent treatment-planned scaling, but subsequent chart notes do not contain follow up on this planned treatment.

75. On or about August 14, 2008, the Respondent extracted Tooth #1. However, the Respondent's documentation of the treatment was inadequate. The Respondent failed to document any post-operative instructions, periodontal examination, or oral cancer screening.

76. On or about October 14, 2010, the Respondent again failed to perform and/or document a head and neck examination, soft and hard tissue examination, or periodontal examination.

77. On or about June 18, 2012, the Respondent failed to document what the chief complaint was, what the symptoms were, and any examination findings. The Respondent took periapical radiographs but did not document any findings.

78. The Respondent prescribed Percocet without documented medical necessity. The Respondent recommended RCT on Tooth #6 but failed to document a diagnosis necessitating such treatment, and failed to document any alternative treatments available.

79. On or about June 29, 2012, the Respondent appears to have performed RCT. The Respondent failed to document a diagnosis or whether he used a rubber dam.

80. On or about August 23, 2012, the Respondent failed to document, treat, or diagnose decay in Tooth #7, which was visible on radiographs taken on this date.

81. On or about October 3, 2013, the Respondent took bitewing radiographs that were insufficient for diagnostic purposes because portions of the premolars and

molars were not visible. In addition, the Respondent took a periapical radiograph of tooth #18 without documenting the necessity for the radiograph or any findings resulting from it.

82. The Respondent again failed to perform and/or document a head and neck examination, soft and hard tissue examination, or periodontal examination.

83. On or about November 14, 2013, the Respondent took a periapical radiograph of Tooth #31 without documenting the necessity for the radiograph or any findings resulting from it.

84. On or about December 2, 2013, the Respondent failed to document a chief complaint. Again, the Respondent took a periapical radiograph without documenting the necessity for the radiograph or any findings resulting from it.

85. On or about August 28, 2014, the Respondent noted the need for RCT on Tooth #7. The Respondent failed to formulate or record a diagnosis, and failed to document findings from an examination or radiographic findings.

86. On or about September 16, 2014, the Respondent provided anesthesia without documenting his reason for doing so. The Respondent provided no follow-up regarding Tooth #7, which had been planned for RCT.

87. On or about September 22, 2014, The Respondent again provided no follow-up regarding Tooth #7, which had been planned for RCT. The Respondent placed a new post in Tooth #6.

88. The Respondent again prescribed Tylenol #3 (Acetaminophen/Codeine) and PenVK (Penicillin V potassium) but failed to document any medical necessity for these prescriptions.

89. On or about November 14, 2014, the Respondent noted that Patient D may need a night guard but did not record a diagnosis to support the recommendation.

90. In addition, a periapical radiograph taken this day (although not documented) shows that the parapost placed on September 22, 2014 is too short, and angled to the side of the root.

91. On or about December 1, 2014, the Respondent extracted Tooth #6 but failed to record a diagnosis or clinical basis to justify the treatment. The accompanying radiograph, which provided the basis for the treatment but which are not documented in the chart, appears to be from a different patient.

92. The Respondent failed to document post-operative instructions.

93. The Respondent prepared a bridge, but failed to document which teeth were involved, and failed to document any alternative treatment available.

94. The Respondent again prescribed Tylenol #3 (Acetaminophen/Codeine) and PenVK (Penicillin V potassium) but failed to document any medical necessity for these prescriptions.

95. On or about December 16, 2014, the Respondent prescribed Peridex, but failed to document any medical necessity for these prescriptions. Radiographs accompanying the chart, although not documented, show an instrument inside of the canal, angled to the side of the root, and shows Tooth #6 still present, although he documented he extracted it on December 1, 2014.

96. Throughout the Respondent's treatment of Patient D, the Respondent failed to provide routine prophylaxis, and never documented performing periodontal examinations. Nevertheless, the chart contains an undated referral to a periodontist for

evaluation and treatment (for what specifically is left unstated). The chart contains a letter from the periodontist, who stated that Patient D had chronic periodontitis. The periodontist made other recommendations regarding endodontic treatment. The Respondent, however, failed to document any referral of Patient D to a specialist or other follow-up.

97. The Respondent's dental treatment and care of Patient D were grossly deficient for reasons including, but not limited to:

A. Failing to document Patient D's chief complaints in detail;

B. Failing to competently place a parapost on Tooth #6;

C. Failing to document appropriate radiographs, examinations, and findings;

D. Failing to properly ensure that radiographs accompanying the patient's chart, which provides the basis for treatment, are of the correct patient;

E. Performing RCT and extraction of Tooth #6 without documented clinical support;

F. Failing to provide post-operative instructions; and

G. Failing to document the necessity of prescription medications.

Patient E

98. Patient E, a female born in the 1970s, initially saw the Respondent for treatment on or about August 10, 2007. On this date, the Respondent failed to document and/or perform an oral cancer screening, a head and neck examination, or a

medical history review. The Respondent also failed to note Patient E's periodontal status or perform and/or document intraoral or extraoral examinations.

99. On this date, the Respondent extracted Tooth #19, but failed to adequately document the extraction, or document any post-operative instructions.

100. On or about June 29, 2010, the Respondent extracted Tooth #12 but failed to adequately document the extraction.

101. On or about February 17, 2014, the Respondent extracted Tooth #30 but failed to adequately document the extraction.

102. On or about February 24, 2014, the Respondent prescribed Keflex and Percocet but failed to document the necessity of the medications.

103. The chart also includes a radiograph dated September 14, 2015, but apparently the date is incorrect, as it shows Teeth #12 and #30 still present even though they had been extracted on prior visits.

104. On or about September 1, 2015, the Respondent noted a chief complaint relating to Teeth #17 and #18 but failed to document the nature of the complaint. The Respondent prescribed PenVK but failed to document the necessity for the medication.

105. On or about September 8, 2015, the Respondent again prescribed Keflex but failed to document the necessity for the medication.

106. On or about September 14, 2015, the Respondent extracted Teeth #17 and #18 but failed to adequately document the treatment, including diagnosis. The Respondent also failed to document any post-operative instructions.

107. On or about September 17, 2015, the Respondent documented swelling, but failed to document any other details, such as the location, type, or odor. In addition, the Respondent failed to document any oral examination.

108. The Respondent prescribed Keflex and Percocet but failed to document the necessity for the medications.

109. Throughout the Respondent's treatment of Patient E, the Respondent failed to properly document periodontal examinations, oral cancer screenings, intral/extraoral examination, or head and neck examinations.

110. Patient E subsequently saw specialists who documented swelling and visible bone at the site of Tooth #17 and pain and severe bone loss near Patient E's wisdom teeth.

111. The Respondent's dental treatment and care of Patient E were grossly deficient for reasons including, but not limited to:

A. Failing to document Patient E's chief complaints in detail;

B. Failing to document appropriate examinations and findings;

C. Failing to provide post operative instructions; and

D. Failing to document the necessity of prescription medications; and

E. Failing to properly refer to specialist.

V. GROUNDS FOR DISCIPLINE

112. The Respondent's conduct, as set forth in paragraphs 14 through 39 of these charges, constitutes, in whole or in part: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry

profession, in violation of Health Occ. I § 4-315(a)(16); violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.23.01B and C(2), (7)(a), (b) and (d), and (8), in violation of § 4-315(a)(20); and willfully and without legal justification, failing to cooperate with a lawful investigation conducted by the Board, in violation of § 4-315(a)(34).

113. The Respondent's willful failure to disclose in the 2016 Renewal that he was under investigation by the Board based on five pending complaints constitutes: fraudulently or deceptively obtaining or attempting to obtain a license for the licensee, in violation of Health Occ. I § 4-315(a)(1); behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. I § 4-315(a)(16); violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.23.01B and C(2) and (8), in violation of § 4-315(a)(20); and willfully making or filing a false report or record in the practice of dentistry, in violation of § 4-315(a)(22).

114. The Respondent's treatment and care of Patients A through E, as set forth in paragraphs 44 through 111 of these charges, constitute, in whole or in part: practicing dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of Health Occ. I § 4-315(a)(6); behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of § 4-315(a)(16); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.23.01B and C(2) and (8), and COMAR 10.44.30.02I(7), K(1), (2) and (4), and COMAR 10.44.30.03A(4), (5), (6), (7), (11)(a) through (d), (13) and (2), and COMAR 10.44.30.05, in violation of § 4-315(a)(20).

NOTICE OF POSSIBLE SANCTIONS

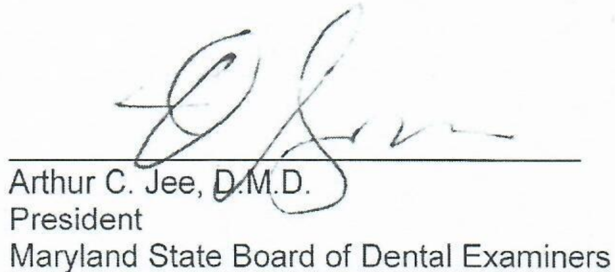
If, after a hearing, the Board finds that there are grounds for action under Health Occ. I § 4-315(a)(1), (6), (16), (20), (22) and/or (34), it may impose disciplinary sanctions in accordance with the Board's regulations under COMAR 10.44.31 *et seq.*, including reprimanding the Respondent, placing the Respondent on probation, or suspending or revoking the Respondent's license, and may impose a monetary penalty.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter has been scheduled for **WEDNESDAY, SEPTEMBER 20, 2017, 9:30 A.M.,** at the Board's offices, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue/ Tulip Drive, Catonsville, Maryland 21228.

The nature and purpose of the CRC is described in the attached letter to the Respondent. If this case is not resolved at the CRC, an evidentiary hearing will be scheduled.

7/5/17
Date



Arthur C. Jee, D.M.D.
President
Maryland State Board of Dental Examiners