CARL M. RUDERMAN, D.D.S.
License Number: 6827

Arpana Singh Verma, D.D.S.
Board President
Maryland State Board of Dental Examiners
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21613

RE: **PERMANENT SURRENDER OF LICENSE**
License Number: 6827
Case Number: 2022-092

Dear Dr. Verma 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 6827, effective six (6) months after the execution of this letter by the Board President or the sale of my dental practice, whichever is earlier. From the time I sign this Permanent Letter of Surrender until its effective date, I agree not to practice dentistry in Maryland in any form as it is defined in the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 4-101 (2021 Repl. Vol.), other than my ownership of my dental practice. I also acknowledge that the Board's Order for Summary Suspension of my dental license issued on April 6, 2022, will remain in effect until the effective date of this Permanent Letter of Surrender. I understand and agree that immediately upon the execution of this Permanent Letter of Surrender, I may not represent myself to the public by title, description of services, methods, procedures, or otherwise that I am licensed to practice dentistry in Maryland.

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 surrender my license to practice dentistry in Maryland was prompted by the Maryland State Board of Dental Examiners' (the "Board's") summary suspension of my license on April 6, 2022, based a complaint from a former patient's parents (the "Complainants") alleging, among other things, that I was responsible for the death of their daughter (the "Patient") by hypoxic injury and subsequent cardiac arrest during my treatment of her on June 16, 2021. The Board's subsequent investigation, which included an expert review, determined that I practiced dentistry in a professionally and grossly incompetent manner, demonstrated a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care, provided dental service

in a manner that is significantly inconsistent with generally accepted professional standards of care, and engaged in unprofessional conduct as an anesthesia provider. The Board's expert review found that I: 1) kept inadequate dental records; 2) demonstrated lack of professional ability and proper administration of deep sedation/general anesthesia; 3) failed to monitor during the operation or provide appropriate emergency care when the Patient became distressed; 4) kept inadequate documentation, which led to discrepancies regarding the timeline of events; and 5) failed to timely and properly report the Patient's death or hospitalization as required by the Board's regulations. **(A copy of the Board's Summary Suspension of License to Practice Dentistry is attached hereto and incorporated herein.)**

For the purposes of this licensing action, I have decided to surrender my license due to my intention to retire from the practice of dentistry and to avoid the time, effort, and cost to defend against these allegations. Nevertheless, I understand that if the Board were to proceed with a disciplinary action and evidentiary hearing in this matter, the State would be able to prove by a preponderance of the evidence that I practiced dentistry in a professionally or grossly incompetent manner, demonstrated a course of conduct that is inconsistent with generally accepted professional standards of care, provided a dental service in a manner that was significantly inconsistent with generally accepted professional standards of care; violated rule or regulations adopted by the Board, and behaved dishonorably or unprofessionally in the practice of dentistry.

I wish to state clearly that I have voluntarily, knowingly, and freely chosen to submit this Permanent Letter of Surrender. I understand that by signing this Permanent Letter of Surrender, I am waiving the right to contest any potential charges the Board may issue relating to my treatment of the Patient 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 execution of this Permanent Letter of Surrender, I shall surrender to the Board any indicia of Maryland dentistry license that is in my possession, including my Maryland dental license, number 6827, any wall certificate, renewal certificates and wallet-sized renewal cards. 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 permanently 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 should 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 license will remain permanently surrendered, and I may not apply for a reinstatement of my license.

I acknowledge that I may not rescind this 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 had the opportunity to consult with an attorney and elected not to do so before signing this Permanent Letter of Surrender, and I make this decision knowingly and voluntarily and without any duress.

Sincerely yours,

6/29/22
Date

Carl M. Ruderman

NOTARY PUBLIC

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 29th day of June, 2022, before me, a Notary Public of the State and City/County aforesaid, personally appeared Carl M. Ruderman, 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.

Notary Public

My Commission expires: 4-22-23

ACCEPTANCE

On this 28th day of July, 2022, I, Arpana Singh Verma, D.D.S., on behalf of the Maryland State Board of Dental Examiners, accept Carl M. Ruderman's **PUBLIC PERMANENT SURRENDER** of his license to practice dentistry in the State of Maryland.

Arpana Singh Verma, D.D.S.
Board President
Maryland State Board of Dental Examiners

IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CARL M. RUDERMAN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 6827	*	**Case Number: 2022-092**

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

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **CARL M. RUDERMAN, D.D.S.** (the "Respondent"), License Number 6827, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c) (2021 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

The Board bases its action on the following findings: [1]

I. LICENSING 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 November 8, 1978, under License Number 6827. The Respondent's license is current through June 30, 2023.

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. 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 this matter.

2. At all times relevant, the Respondent practiced dentistry at his private dental practice located at 6309 Baltimore Avenue, Suite 202, Riverdale, Maryland 20737 (the "Office").

II. COMPLAINT

3. On or about January 14, 2022, the Board received a complaint from a former patient's parents (the "Complainants") at the Office alleging, among other things, that the Respondent was responsible for the death of their daughter (the "Patient") by hypoxic brain injury and subsequent cardiac arrest based on his treatment of her on June 16, 2021.

4. Based on the complaint, the Board initiated an investigation.

III. INVESTIGATION

5. In furtherance of the investigation, the Board's investigator obtained relevant documents, including the Patient's pediatric medical records, the Patient's dental treatment records from the Respondent, records from EMS, and records from the hospital (the "Hospital") to which she was transported by EMS in a state of cardiac arrest after becoming non-responsive under the Respondent's care, and an autopsy report produced by the Hospital. The Investigator also obtained relevant records from the National Practitioner Database.

Summary of Treatment

6. Based on the records obtained, the Respondent first saw the Patient on or about May 4, 2021 for consultation and radiographs in preparation for removal of her third molars (wisdom teeth).

7. On or about June 16, 2021, the Respondent treated the Patient for removal of her third molars. It was during this treatment that the Patient became non-responsive.

The Patient's Pediatric Medical Records

8. In relevant part, the Patient's pediatric medical records indicate that her cardiovascular and respiratory systems were within normal functioning. A note for diet counseling mentions that she was chronically underweight.

The Respondent's Notes

9. At the initial visit on May 4, 2021, the Respondent failed to document the Patient's height, weight, or patient physical status.

10. On June 16, 2021, the Respondent administered sedation to the Patient including solutions of Versed, Fentanyl, and Propofol, as well as lidocaine with epinephrine, but he failed to document the concentrations of the drugs present in solution in actual milligrams of the drug per cc of solution. Therefore, it would be impossible to calculate a proper drug dosage, as proper dosages are calculated in milligrams of the drug itself per kilogram of body weight in order to properly prevent under or over usages (or overdose).

11. The Respondent noted an anesthesia graph, but no actual times for the administration of each drug was noted. A practitioner would be unable to evaluate individual drug effect if he is not monitoring and observing each drug's actions as administered.

12. The Respondent's records contain no direct listing of what patient-monitoring equipment he was using, e.g. pulse oximeter, etc. Further, the Respondent

failed to record the settings for monitoring e.g. every 3 minutes, 5 minutes, or other interval, nor did he record what individual staff member was actually monitoring the Patient's vital signs.

13. In fact, the Respondent's notes failed to contain any detailed listing of which staff were present in the operatory doctor, and their individual responsibilities.

14. The records contain only one EKG graph, which contradicts the written documentation. The hand-written notes state at 9:10 a.m., the Patient had the following readings: bp (blood pressure) 106/77, p (pulse) 91, spo2 (oxygen) 99 %, etco2 (carbon dioxide) 35. However, the printed EKG readout documents a start of 9:07 a.m., with the following readings: hr (heartrate) 36, spo2 [BLANK], nibp (blood pressure) 73/37, etco2 11.

15. Handwritten notes included in the documentation, dated June 18, 2021 state that they were transcribed by an assistant of the Respondent's 'over phone on 6/18/21, 6/24/21, 6/25/21" (apparently from dictation by the Respondent, but this information is not noted) but do not provide any additional appropriate clinically relevant information. The June 18, 2021 transcribed note contains no discussion of airway, IV access, or advanced cardiovascular life support (ACLS), and no time-line that clearly documents the events.

16. Rather, the note demonstrates a lack of appropriate dental and/or medical terminology regarding emergency protocol to resuscitate the Patient. The efforts noted are "2 rounds CPR" (no time noted); and "ammonia inhalant" which is not an appropriate recognized medical or dental protocol. The note cryptically states "AED [automated external defibrillator] placed on counter" but failed to note any actual use of the AED.

EMS Records

17. At approximately 10:14 a.m. on June 16, 2021, Prince Georges County EMS arrived on scene. According to the records EMS documented the following: the Patient's bodyweight was estimated at 90 pounds (40.8 kilograms); the Patient "was recognized as being non-responsive by dental staff person around 10 am...."; "...AED was present but not used" and " I/O was utilized," which suggests IV access was compromised.[2]

Autopsy Report

18. The Patient's autopsy report states: "The cause of death in this patient is cardiopulmonary arrest."

Expert Review

19. After obtaining the relevant records, the Board submitted the records to an independent reviewer (the "Expert") who is board-certified in Oral Maxillofacial Surgery and Dental Anesthesia for a review of the Respondent's care of the Patient.

20. Based on his review of the case materials, the Expert submitted a written report to the Board, in which he concluded that the Respondent

> practices dentistry in a professionally and grossly incompetent manner, demonstrates a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care, provides dental service in a manner that is significantly inconsistent with generally accepted professional standards of care, and engages in unprofessional conduct as an anesthesia provider.

[2] When IV access cannot be achieved, I/O, intraosseous, access is an alternative, especially in pediatric emergencies when time is critical. I/O line delivers fluid, blood, or medication through a needle inserted directly into the marrow of a bone.

21. Specifically, the Expert based his conclusions on findings in the following areas:

A. The Respondent's inadequate dental recordkeeping:

1. No recording of body weight and height necessary for determining accurate dosages in medications

2. Lack of documenting accurately the dosages of medications utilized in administration of anesthesia

3. Lack of timeline of when, how, and sequence of the administration of anesthesia medication

4. Lack of adequate documentation of vital signs throughout procedure

5. Lack of anesthesia documentation regarding who is providing anesthesia, personnel present, and responsibilities of personnel

6. Failure to document monitoring type, frequency, and identifying a responsible person as recorder

7. Lack of documentation either during or after emergency event, i.e. a clear timeline, specific measures taken – IV, airway, treatments, and specific detail of office protocol procedures

8. Lack of personally signed documentation

9. Lack of signed postmortem chart notations as to event, assessments and debriefing

10. Lack of documentation of the details of the surgical procedure

B. The Respondent's demonstrated lack of professional ability and proper of deep sedation/general anesthesia:

1. Failure to specify dosages of sedation medications in milligrams rather than cubic centimeters (cc) throughout chart. The standard dosing for medications is milligrams of drug per kilograms of body weight. Without using proper measurement, one cannot effectively determine a proper administration of the drug or

establish overdose criteria for the individual patient, especially given the Patient's underweight.

2. Lack of standard documentation of the timeline and sequencing of the Respondent's administration of sedation drugs reflects a lack of knowledge or appreciation of the effects of each drug and overall effects of drugs combined.

C. The Respondent's failure to monitor during the operation or provide appropriate emergency care when the Patient became distressed:

1. Lack of documentation of proper peri-operative or intra-operative monitoring beyond the initial measurement of vital signs.

2. The Respondent's documentation is not adequate to clearly reconstruct when, where in the procedure timeline, or how the Respondent or his staff recognized the emergency.

3. There is no documentation of emergency treatment beyond "ammonia inhalant" and "two rounds CPR." For example, there is no notation of switching to 100% oxygen, maintenance airway otherwise, use of reversal drugs, controlling IV.

4. Failure to use the AED that was in the Office.

5. There is no documentation of the presence or use of reversal drugs, e.g. Romazicon or Narcan/naloxone.

D. The Respondent's inadequate documentation leads to discrepancies regarding the timeline of events:

1. Only one (1) EKG available shows it was taken at 9:07 a.m., an already indicates dysrhythmia, bradycardic, hypotensive vital signs. EMS documents show there was no call from the Respondent's to EMS until 10:00 a.m. EMS records also state that at 10:14 a.m., "staff [were] performing CPR on arrival."

2. However, the Respondent's 'transcribed notes' indicate that "two (2) rounds CPR," were performed and vital signs returned *before* the EKG then recorded..." This *post facto* account is likely mistaken. It suggests that the EKG was taken *after* administration of sedation, after distress was noted, and after CPR, while the EMS records, the EKG printout time, and the original handwritten note

indicate the EKG was taken at the beginning of the operation, before the emergency was noted and before any CPR was administered. The lack of a clearly documented and consistent timeline indicates a lack of professionally competent care.

E. Finally, the Respondent's failure to timely and properly report the Patient's death or hospitalization as required by the Board's regulations.[3]

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent's continued practice of dentistry in the State of Maryland poses a substantial risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license, pursuant to State Gov't § 10-226(c)(2) (2021 Repl. Vol.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of the Board considering this case, pursuant to authority granted to the Board by State Gov't § 10-226(c)(2) (2021 Repl. Vol.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 6827, is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the date of the Respondent's request, at which the

[3] *See* COMAR 10.44.12.36 Morbidity and Mortality Reports.

Respondent will be given an opportunity to be heard as to why the Order for Summary Suspension should not continue; and it is further

ORDERED that if the Respondent fails to request a Show Cause Hearing or files a written request for a Show Cause Hearing and fails to appear, the Summary Suspension of his license shall continue; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all indicia of licensure to practice dentistry issued by the Board that are in his possession, including but not limited to his original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2019).

4/6/2020
Date

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

NOTICE OF HEARING

Upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing will be held at the offices of the Maryland State Board of Dental Examiners, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Catonsville, Maryland

21228.[4] The Show Cause Hearing will be scheduled for the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the Board's receipt of a written request for a hearing filed by the Respondent.

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request for an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of State Gov't §§ 10-201 *et seq.* (2021 Repl. Vol.).

[4] The Board may conduct any hearings remotely via teleconference. The Respondent will be notified of the procedure before the relevant hearing.

CARL M. RUDERMAN, D.D.S.
License Number: 6827

Arpana Singh Verma, D.D.S.
Board President
Maryland State Board of Dental Examiners
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21613

RE: **PERMANENT SURRENDER OF LICENSE**
License Number: 6827
Case Number: 2022-092

Dear Dr. Verma 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 6827, effective six (6) months after the execution of this letter by the Board President or the sale of my dental practice, whichever is earlier. From the time I sign this Permanent Letter of Surrender until its effective date, I agree not to practice dentistry in Maryland in any form as it is defined in the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 4-101 (2021 Repl. Vol.), other than my ownership of my dental practice. I also acknowledge that the Board's Order for Summary Suspension of my dental license issued on April 6, 2022, will remain in effect until the effective date of this Permanent Letter of Surrender. I understand and agree that immediately upon the execution of this Permanent Letter of Surrender, I may not represent myself to the public by title, description of services, methods, procedures, or otherwise that I am licensed to practice dentistry in Maryland.

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 surrender my license to practice dentistry in Maryland was prompted by the Maryland State Board of Dental Examiners' (the "Board's") summary suspension of my license on April 6, 2022, based a complaint from a former patient's parents (the "Complainants") alleging, among other things, that I was responsible for the death of their daughter (the "Patient") by hypoxic injury and subsequent cardiac arrest during my treatment of her on June 16, 2021. The Board's subsequent investigation, which included an expert review, determined that I practiced dentistry in a professionally and grossly incompetent manner, demonstrated a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care, provided dental service

in a manner that is significantly inconsistent with generally accepted professional standards of care, and engaged in unprofessional conduct as an anesthesia provider. The Board's expert review found that I: 1) kept inadequate dental records; 2) demonstrated lack of professional ability and proper administration of deep sedation/general anesthesia; 3) failed to monitor during the operation or provide appropriate emergency care when the Patient became distressed; 4) kept inadequate documentation, which led to discrepancies regarding the timeline of events; and 5) failed to timely and properly report the Patient's death or hospitalization as required by the Board's regulations. **(A copy of the Board's Summary Suspension of License to Practice Dentistry is attached hereto and incorporated herein.)**

For the purposes of this licensing action, I have decided to surrender my license due to my intention to retire from the practice of dentistry and to avoid the time, effort, and cost to defend against these allegations. Nevertheless, I understand that if the Board were to proceed with a disciplinary action and evidentiary hearing in this matter, the State would be able to prove by a preponderance of the evidence that I practiced dentistry in a professionally or grossly incompetent manner, demonstrated a course of conduct that is inconsistent with generally accepted professional standards of care, provided a dental service in a manner that was significantly inconsistent with generally accepted professional standards of care; violated rule or regulations adopted by the Board, and behaved dishonorably or unprofessionally in the practice of dentistry.

I wish to state clearly that I have voluntarily, knowingly, and freely chosen to submit this Permanent Letter of Surrender. I understand that by signing this Permanent Letter of Surrender, I am waiving the right to contest any potential charges the Board may issue relating to my treatment of the Patient 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.

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Sincerely yours,

6/29/22
Date

Carl M. Ruderman

NOTARY PUBLIC

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 29th day of June, 2022, before me, a Notary Public of the State and City/County aforesaid, personally appeared Carl M. Ruderman, 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.

Notary Public

My Commission expires: 4-22-23

IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CARL M. RUDERMAN, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 6827	*	**Case Number: 2022-092**

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

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **CARL M. RUDERMAN, D.D.S.** (the "Respondent"), License Number 6827, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("State Gov't") § 10-226(c) (2021 Repl. Vol.), finding that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

The Board bases its action on the following findings: [1]

I. LICENSING 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 November 8, 1978, under License Number 6827. The Respondent's license is current through June 30, 2023.

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[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. 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 this matter.

2. At all times relevant, the Respondent practiced dentistry at his private dental practice located at 6309 Baltimore Avenue, Suite 202, Riverdale, Maryland 20737 (the "Office").

II. COMPLAINT

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failed to record the settings for monitoring e.g. every 3 minutes, 5 minutes, or other interval, nor did he record what individual staff member was actually monitoring the Patient's vital signs.

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3. Lack of timeline of when, how, and sequence of the administration of anesthesia medication

4. Lack of adequate documentation of vital signs throughout procedure

5. Lack of anesthesia documentation regarding who is providing anesthesia, personnel present, and responsibilities of personnel

6. Failure to document monitoring type, frequency, and identifying a responsible person as recorder

7. Lack of documentation either during or after emergency event, i.e. a clear timeline, specific measures taken – IV, airway, treatments, and specific detail of office protocol procedures

8. Lack of personally signed documentation

9. Lack of signed postmortem chart notations as to event, assessments and debriefing

10. Lack of documentation of the details of the surgical procedure

B. The Respondent's demonstrated lack of professional ability and proper of deep sedation/general anesthesia:

1. Failure to specify dosages of sedation medications in milligrams rather than cubic centimeters (cc) throughout chart. The standard dosing for medications is milligrams of drug per kilograms of body weight. Without using proper measurement, one cannot effectively determine a proper administration of the drug or

establish overdose criteria for the individual patient, especially given the Patient's underweight.

2. Lack of standard documentation of the timeline and sequencing of the Respondent's administration of sedation drugs reflects a lack of knowledge or appreciation of the effects of each drug and overall effects of drugs combined.

C. The Respondent's failure to monitor during the operation or provide appropriate emergency care when the Patient became distressed:

1. Lack of documentation of proper peri-operative or intra-operative monitoring beyond the initial measurement of vital signs.

2. The Respondent's documentation is not adequate to clearly reconstruct when, where in the procedure timeline, or how the Respondent or his staff recognized the emergency.

3. There is no documentation of emergency treatment beyond "ammonia inhalant" and "two rounds CPR." For example, there is no notation of switching to 100% oxygen, maintenance airway otherwise, use of reversal drugs, controlling IV.

4. Failure to use the AED that was in the Office.

5. There is no documentation of the presence or use of reversal drugs, e.g. Romazicon or Narcan/naloxone.

D. The Respondent's inadequate documentation leads to discrepancies regarding the timeline of events:

1. Only one (1) EKG available shows it was taken at 9:07 a.m., an already indicates dysrhythmia, bradycardic, hypotensive vital signs. EMS documents show there was no call from the Respondent's to EMS until 10:00 a.m. EMS records also state that at 10:14 a.m., "staff [were] performing CPR on arrival."

2. However, the Respondent's 'transcribed notes' indicate that "two (2) rounds CPR," were performed and vital signs returned *before* the EKG then recorded..." This *post facto* account is likely mistaken. It suggests that the EKG was taken *after* administration of sedation, after distress was noted, and after CPR, while the EMS records, the EKG printout time, and the original handwritten note

indicate the EKG was taken at the beginning of the operation, before the emergency was noted and before any CPR was administered. The lack of a clearly documented and consistent timeline indicates a lack of professionally competent care.

E. Finally, the Respondent's failure to timely and properly report the Patient's death or hospitalization as required by the Board's regulations.[3]

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that there is a substantial likelihood that the Respondent's continued practice of dentistry in the State of Maryland poses a substantial risk of harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license, pursuant to State Gov't § 10-226(c)(2) (2021 Repl. Vol.).

ORDER

Based on the foregoing investigative findings, it is, by a majority of the Board considering this case, pursuant to authority granted to the Board by State Gov't § 10-226(c)(2) (2021 Repl. Vol.):

ORDERED that the Respondent's license to practice dentistry in the State of Maryland, License Number 6827, is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing shall be scheduled at the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the date of the Respondent's request, at which the

[3] *See* COMAR 10.44.12.36 Morbidity and Mortality Reports.

Respondent will be given an opportunity to be heard as to why the Order for Summary Suspension should not continue; and it is further

ORDERED that if the Respondent fails to request a Show Cause Hearing or files a written request for a Show Cause Hearing and fails to appear, the Summary Suspension of his license shall continue; and it is further

ORDERED that upon service of this Order for Summary Suspension, the Respondent shall immediately surrender to the Board all indicia of licensure to practice dentistry issued by the Board that are in his possession, including but not limited to his original license, renewal certificates and wallet size license; and it is further

ORDERED that this document constitutes an order of the Board and is therefore a public document for purposes of public disclosure, as required by Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2019).

4/6/2022
Date

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

NOTICE OF HEARING

Upon the Board's receipt of a written request from the Respondent, a Show Cause Hearing will be held at the offices of the Maryland State Board of Dental Examiners, Spring Grove Hospital Center, Benjamin Rush Building, 55 Wade Avenue, Catonsville, Maryland

21228.[4] The Show Cause Hearing will be scheduled for the Board's next regularly scheduled meeting but not to exceed thirty (30) days from the Board's receipt of a written request for a hearing filed by the Respondent.

At the conclusion of the Show Cause Hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, file a written request for an evidentiary hearing. Unless otherwise agreed to by the parties, the Board shall provide a hearing within forty-five (45) days of the Respondent's written request. The Board shall conduct an evidentiary hearing under the contested case provisions of State Gov't §§ 10-201 *et seq.* (2021 Repl. Vol.).

[4] The Board may conduct any hearings remotely via teleconference. The Respondent will be notified of the procedure before the relevant hearing.