BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In The Matter Of:	)	
ANDREW W. KELLY, D.D.S.	)	CONSENT ORDER
(License No. 7350)	)	
	)	

THIS MATTER is before the North Carolina State Board of Dental Examiners (Board) as authorized by G.S. §90-41.1 (b) for consideration of a Consent Order in lieu of a formal administrative hearing. David Freedman and Dudley Witt represented the Respondent. Douglas J. Brocker and Crystal Carlisle represented the Investigative Panel.

Based upon the consent of the parties hereto, the Board enters the following:

FINDINGS OF FACT

1. The North Carolina State Board of Dental Examiners is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act and the Rules and Regulations of the North Carolina State Board of Dental Examiners.

2. Respondent was licensed to practice dentistry in North Carolina on July 17, 2001 and holds license number 7350.

3. Respondent has remained licensed to practice dentistry in North Carolina at all times since July 7, 2001 and was subject to the Dental Practice Act and the Board's Rules and Regulations at all times relevant hereto.

4. On August 18, 2011, the Respondent voluntarily signed a Consent Order (hereafter, 2011 CO), which found that he had violated the Dental Practice Act in several respects, including placing implants for patient GF without obtaining proper consent.

5. Pursuant to the 2011 CO, the Respondent's North Carolina dental license was suspended for one (1) year. The Respondent's license was immediately reinstated, with no active suspension, on condition, among other things, that the Respondent complied with all provisions of the Dental Practice Act for five years.

6. The Respondent was aware of the terms of the 2011 CO, which remained binding upon him at all times relevant hereto.

7. On April 10, 2012, patient BM presented to the Respondent's dental practice for the extraction of her remaining five upper teeth.

8. BM reported to Respondent or his office that she had a previous heart attack, heart disease, respiratory disease, at least one cardiac stent, pulmonary disease, and diabetes and was taking a beta blocker, ace inhibitor, and metformin.

9. Respondent's treatment notes contain no record that:

a. BM's height or weight were measured;

b. an evaluation was performed to evaluate BM's airway prior to the procedure; or

c. Respondent consulted with BM's physician in order to discuss the proposed surgery and sedation or to further understand the extent of BM's pulmonary and cardiovascular disease.

10. During the appointment, the Respondent administered 0.25 mg of Halcion to BM orally and 5 mg of Versed intramuscularly. Respondent noted in his records that BM experienced sleep apnea during the procedure.

11. BM consented to receive oral sedation but did not give informed consent for the administration of intramuscular (IM) sedation.

12. Respondent's treatment notes indicate that:

a. He did little if any pre-operative planning to treat BM,

b. BM was a poor ASA risk for sedation,

c. Respondent poorly monitored BM during the procedure, and

d. Respondent overdosed BM with Halcion and Versed.

13. Post-procedure, BM remained heavily sedated and later that afternoon, she became unresponsive with labored breathing.

14. BM's family ultimately contacted emergency services after Respondent or his office staff informed them that her condition was normal but to bring her to see Respondent if they were concerned.

15. Upon examination at the hospital, BM was determined to have very low oxygen saturation and medication-induced encephalopathy. She was admitted to the hospital overnight for observation.

16. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated BM required dentists to:

a. recognize patients who are not good candidates for sedation and refrain from administering sedation to such patients,

b. obtain informed patient consent for all sedation administered,

c. be informed and administer the appropriate dosage of sedation medication to administer to patients,

d. perform appropriate pre-operative planning, proper monitoring and airway management of patients during procedures,

e. maintain proper recordkeeping during procedures, and

f. promptly recognize when a patient is in distress or danger and take appropriate action, including involving emergency services.

17. By failing to treat BM consistent with the requirements set out in paragraph 16, Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina and thereby engaged in negligence in the practice of dentistry, in violation of G.S. 90-41(a)(12) and (a)(6).

18. In September 2009, patient PM presented to the Respondent's dental office to discuss having implants placed.

19. Following an examination, the Respondent developed a treatment plan for PM that called for the extraction of teeth numbers 18-20, 27, 29 and 30, implants at teeth 23 and 26 and the placement of a lower denture.

20. PM timely advised the Respondent that he had received multiple doses of radiation therapy in 2005 to treat cancer of the tongue.

21. The Respondent failed to consult with PM's radiation oncology physician or take other steps to determine if PM was a good candidate for implants and to determine if PM needed hyperbaric oxygen or other treatment before the planned oral surgery.

22. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated PM required that dentists who treatment plan implants for a patient who has received radiation therapy to the head and neck region to thoroughly investigate the patient's medical history, including consulting with the patient's radiation oncology physician, before proceeding with implants.

23. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated PM also required that dentists considering oral surgery on a patient with a history of radiation therapy to the head and neck region to determine if the patient required hyperbaric oxygen or other treatment before oral surgery.

24. By violating the standard of care as set out in paragraphs 22-23, the Respondent engaged in negligence in the practice of dentistry, in violation of G.S. § 90-41(a)(12) and (6).

25. On October 21, 2009, with PM's consent, the Respondent placed implants at the sites of teeth numbers 23 and 26.

26. On August 24, 2010, the implant at PM's tooth # 23 failed.

27. On September 24, 2010, the Respondent replaced the implant at PM's tooth # 23 and also placed mini-implants at the sites of tooth numbers 22 and 27.

28. PM was not aware of and did not consent to the placement of the mini-implants at the sites of tooth numbers 22 and 27.

29. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated PM required dentists to obtain informed patient consent for all implant procedures.

30. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to obtain informed consent from PM for the placement of mini-implants at the sites of teeth numbers 22 and 27.

31. In or prior to 2004, patient RD had four implants placed in his lower arch. The implants are Nobel Biocare Replace Select Tri Channel and are cylindrical internally.

32. Patient RD subsequently had his lower arch restored by a bar retained overdenture with clips.

33. On July 2, 2012, RD presented to the Respondent's practice complaining that the denture had become detached.

34. On July 20, 2012, the Respondent replaced the abutments on RD's denture with Hiossen conical-shaped abutments, which did not properly fit RD's implants.

35. The standard of care for dentists licensed to practice dentistry in North Carolina required dentists to select appropriate fitting abutments with which to restore implants.

36. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by placing incorrectly-shaped abutments on RD's denture.

37. On or about May 12, 2015, a comprehensive review of twenty (20) random patient files was conducted by an independent evaluator as directed by the Hearing Panel of the Dental Board in connection with a Summary Suspension Hearing in this matter.

38. Review of the random patient files demonstrated deficiencies in Respondent's sedation treatment of patients AL, JO, TB, TD, AH, AM, AB, WV and WS as described below.

39. Respondent repeatedly used anesthesia medication that is contraindicated and unsafe for general practitioners with a moderate conscious sedation permit, risking unanticipated deep sedation, general anesthesia, and significant respiratory depression.

40. Respondent administered Propofol to patients AL (5/6/14); JO (6/24/14); TB (10/2/14, 10/16/14, 12/10/14); TD (10/7/14); AH (1/6/15); and AM (1/20/15, 2/10/15) while also performing procedures on those patients. Propofol is a general anesthetic Respondent is not permitted to use with a moderate conscious sedation permit.

41. Respondent administered excessive amounts of a number of local anesthetics (29 carpules of various local anesthetic drugs) to patient AL on January 6, 2014.

42. Some of the patient records reviewed indicated that Respondent sedated patients to a level of deep sedation or general anesthesia with periods of apnea or significant respiratory depression and hypoxemia.

43. During the course of this proceeding, it was determined that Respondent was regularly using a monitor on his sedation patients that was subject to interference by his electrical hand piece as it relates to oxygen saturation levels and respiration.

44. Respondent failed to recognize and adequately treat patients for hypertension, hypotension, and respiratory depression when immediate treatment was indicated.

45. Respondent failed to properly select and evaluate patients to undergo procedures under sedation.

46. Respondent sedated patient AL, a morbidly obese, ASA Class III patient on May 6, 2014. Respondent's clinical notes do not indicate Respondent consulted with AL's primary care physician or evaluated AL's airway prior to sedating her.

47. Respondent sedated patient WS on August 4, 2014. Patient WS had a pre-operative blood pressure of 184/114. Respondent sedated patient WV on August 20 and October 8, 2014. Patient WV had a history of hypertension, diabetes and seizures. The health history and records did not include more comprehensive health information for a patient presenting with these conditions.

48. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated patients AL, JO, TB, TD, AH, AM, AB, WV and WS required that dentists:

a. Refrain from using anesthesia medications that are contraindicated and unsafe for use by general practitioners and are intended to result in loss of consciousness thereby risking deep sedation, general anesthesia, and significant respiratory depression.

b. Recognize and appreciate the toxicity of local anesthetic drugs and know the appropriate dosages of these medications to safely administer to patients.

c. Refrain from sedating patients to a level of deep sedation or general anesthesia resulting in periods of apnea or significant respiratory depression and hypoxemia.

d. Perform appropriate pre-operative evaluation of patients, proper monitoring during procedures and proper airway management of patients during procedures.

e. Promptly recognize when a patient is in distress or danger and take appropriate action and remain competent regarding how to handle medical emergencies.

f. Recognize patients who are not good candidates for sedation and refrain from administering sedation to such patients.

g. Obtain complete patient health histories before beginning surgical procedures under sedation.

h. Maintain proper recordkeeping during procedures.

49. Respondent violated the standard of care and thereby engaged in negligence in the practice of dentistry, in violation of G.S. §§ 90-41(a)(12) and (6), by failing to treat patients AL, JO, TB, TD, AH, AM, AB, WV and WS consistent with the requirements in paragraph 48, as set out in paragraphs 37-48.

Based upon the foregoing Findings of Fact and with the consent of the parties hereto, the Hearing Panel enters the following:

CONCLUSIONS OF LAW

1. The North Carolina State Board of Dental Examiners has jurisdiction over the subject matter of this action and over the person of the Respondent.

2. Respondent has stipulated that such allegations are legally sufficient to support Findings and Conclusions that he has violated G.S. 90-41 as specified in the Findings of Fact. Furthermore, Respondent has stipulated that he will not contest the allegations set forth in this Order, which allegations are previously incorporated in this Order, as if fully set forth herein, as Findings of Fact.

3. Respondent violated the applicable standard of care and thereby engaged in negligence in the practice of dentistry, in violation of G.S. §§ 90-41 (a)(6) and (12):

a. In his treatment of Patient BM, as set forth in paragraphs 7-17;

b. In his treatment of Patient PM, as set forth in paragraphs 18-30;

c. In his treatment of Patient RD, as set forth in paragraphs 31-36; and

d. In his treatment of Patients AL, JO, TB, TD, AH, AM, AB, WV and WS, as set forth in paragraphs 37-48.

4. By engaging in negligence in the practice of dentistry during his treatment of BM, RD, AL, JO, TB, TD, AH, AM, AB, WV and WS the Respondent violated his August 2011 CO. The treatment of PM occurred prior to the 2011 CO and therefore did not violate the 2011 CO.

Based upon the foregoing Findings of Fact and Conclusions of Law and with the consent of the parties hereto, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

1. License number 7350 issued to Respondent for the practice of dentistry in North Carolina is suspended for a period of one (1) year. Respondent shall surrender his license and current renewal certificate to the Board at its offices on or before February 1, 2016. During this term of suspension Respondent may, with the Board's prior written approval, lease his dental office and equipment. Any lease approved by the Board must be in writing and must disclose fully all material terms of the transaction. In no event shall any such lease allow operation of the dental practice on behalf of or for the benefit of Respondent.

2. With Respondent's consent, his license to practice dentistry shall be conditionally restored on the ninety-first (91st) day following the surrender of his license, provided that for five (5) years he comply with the following probationary terms and conditions:

(a) Respondent shall violate no provisions of the Dental Practice Act or the Board's Rules and Regulations;

(b) Respondent shall neither permit nor direct any of his employees to violate any provision of the Dental Practice Act or the Board's Rules and regulations;

(c) Respondent shall permit the Board and its agents to inspect and observe his office and patient records and interview employers, employees and co-workers at any time during normal office hours;

(d) Within one (1) year of having his dental license conditionally restored, Respondent shall complete the following two separate continuing education courses, of not less than 24 hours each, specially designed for him by the University of North Carolina or East Carolina School of Dentistry in conjunction with the North Carolina State Board of Dental Examiners directives and approved by it in advance:

i. The first course will be a comprehensive, remedial course to include the following: (1) diagnosis, treatment planning, patient selection and surgical placement of all implant types as well as their prosthetic components; (2) informed patient consent, and (3) appropriate recordkeeping.

ii. The second course will be a comprehensive, remedial course related to dental sedation to include the following: (1) proper patient evaluation and selection, (2) informed patient consent, (3) proper monitoring, (4) appropriate anesthesia recordkeeping; (5) sedation drug selection, dosage and administration, including local anesthesia, and (6) response to patient emergencies.

iii. Respondent shall submit to the Board's Deputy Operations Officer written proof of satisfactory completion of these courses before it will be accepted in satisfaction of this requirement. This requirement shall be in addition to the continuing education required by the Board for the renewal of Respondent's dental license.

(e) Respondent shall not place any dental implants for any patients until he completes all the requirements in paragraph 2(d)(i) above and submits proof of completion to the Board.

(f) Respondent shall not sedate any patients until: (1) he completes all the requirements of paragraph 2(d)(ii) and submits proof of completion to the Board; (2) The Board's new proposed sedation rules go into effect: (3) Respondent satisfy all requirements under the new rules; and (4) A Board approved inspector certify that Respondent has satisfied all the requirements under the Board's new sedation rules for a sedation permit, including maintaining all required equipment and having all necessary training.

(g) Within one (1) year of the date of this Order, Respondent shall reimburse the Board for the costs associated with its investigation of this matter in the amount of $30,931.18.

3. If Respondent fails to comply with any provision of this Order or breaches any term or condition thereof, the Board shall promptly schedule a public Show Cause Hearing to permit Respondent to show cause why his dental license should not be suspended. If, as a result of the Show Cause hearing, the Board is satisfied that Respondent failed to comply with or breached any term or condition of this Order, Respondent's license shall be rescinded and, upon written demand, Respondent shall immediately surrender his license and current renewal certificate to the Board for a period of one (1) year. This sanction shall be in addition to and not in lieu of any sanction the Board may impose as a result of future violations of the Dental Practice Act or the Board's Rules.

This the 11 day of December 2015.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

By _____

Stanley L. Allen, D.D.S.
Presiding Officer

STATEMENT OF CONSENT

I, ANDREW W. KELLY, D.D.S., do hereby certify that I have read the foregoing Consent Order in its entirety I assent to its terms and conditions set out herein. I freely and voluntarily admit that there is a factual basis for the findings of fact herein, that the findings of fact support the conclusions of law and that I will not contest the findings of fact, the conclusions of law, or the order of discipline if further disciplinary action is warranted in this matter. I understand that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order will become part of the Board's permanent public record.

This the 11 day of December, 2015.

ANDREW W. KELLY, D.D.S.