

BEFORE THE IOWA DENTAL BOARD

IN THE MATTER OF THE)	
STATEMENT OF CHARGES)	FINDINGS OF FACT,
AGAINST)	CONCLUSIONS OF LAW
)	DECISION AND ORDER
PETER L. VIDAL, D.D.S.)	
)	
RESPONDENT)	

On October 28, 2009, the Iowa Dental Board (Board) issued a Notice of Hearing and Statement of Charges against Peter L. Vidal, D.D.S. (Respondent) charging him with three counts:

Count I: Unprofessional conduct in the practice of dentistry towards patients and staff persons, in violation of Iowa Code section 153.34(7)(2009).

Count II: Willfully or repeatedly violating a rule of the Board when he issued multiple prescriptions to a patient for controlled substances and failed to record the prescriptions in the patient's dental record, in violation of Iowa Code section 153.34(4)(2009) and 650 IAC 16.2(3).

Count III: Willfully or repeatedly violating a rule of the Board by failure to comply with the decision of the Board imposing discipline, in violation of Iowa Code section 153.34(4)(2009) and 650 IAC 30.4(23).

The hearing was held before the Board on April 7, 2010 in the Board Conference Room at 400 SW 8th Street in Des Moines, Iowa. The following members of the Board presided at the hearing: Deena R. Kuempel, D.D.S., Chairperson; Gary Roth, D.D.S.; Perry T. Grimes, D.D.S.; Michael Rovner, D.D.S.; Lynn Curry, D.D.S.; Marijo Beasler, R.D.H.; Valinda Parsons, R.D.H., Diane Meier and Kimberlee Spillers, public members. Assistant Attorney General Theresa O'Connell Weeg represented the state. Attorney Kevin Driscoll represented Respondent who was also present. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was recorded by a certified court reporter and was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1) and 650 IAC 51.20(13).

The Board, having heard the testimony and having examined the exhibits, and after convening in closed executive session pursuant to Iowa Code section 21.5(1)(f)(2009) to deliberate, directed the administrative law judge to prepare their Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the hearing notices; Respondent's Objections To State's Exhibit List and Motion to Exclude; Rulings on Respondent's Objection to Exhibits/Motion to Exclude; Respondent's Trial Brief; a series of emails dated March 30, March 31, April 5, and April 6, 2010 between the ALJ and the attorneys regarding their evidentiary objections; the testimony of the witnesses, State Exhibits 1, 4-20, 22, 23 (redacted), 24-36, and Respondent Exhibits A-W, GG-JJ, and LL-NN.

FINDINGS OF FACT

Prior Disciplinary Action and Licensure Status

Respondent was issued Iowa dental license number 6152 on July 1, 1976. Respondent's license is current and will next expire on August 31, 2010. Respondent has practiced general dentistry in Garner, Iowa since 1981. Respondent is active in various charitable and service organizations and has been recognized for his willingness to provide dental care to persons of limited economic means. (State Exhibit 5; Respondent Exhibit HH, II, NN; Respondent testimony)

On February 7, 2008, the Board filed a Notice of Hearing and Statement of Charges against Respondent charging him with dishonorable or unprofessional conduct in dentistry by performing unnecessary dental procedures, with obtaining a fee by fraud or misrepresentation, with failure to maintain a satisfactory standard of competency, and with making misleading, deceptive, untruthful, or fraudulent statements in the practice of dentistry. These charges related to Respondent's provision of root canal treatment on Title XIX patients. (State Exhibit 1) On March 10, 2008, Respondent filed an Answer denying all of the allegations and charges against him. (State Exhibit 4)

On February 23, 2009, Respondent and the Board entered into a Stipulation and Consent Order. The Stipulation and Consent Order resolved not only the February 7, 2008 Statement of Charges but also resolved:

...any charges that could be brought forth by the Board, based on any current information in possession of the Iowa Dental Board, its agents, investigators, or employees...

(State Exhibit 4, p. 1). By agreement of the parties, Respondent's license to practice dentistry was indefinitely suspended, and all but thirty days of the suspension was stayed and placed in abeyance. Respondent's dental license was placed on probation until further order of the Board, subject to a number of terms and conditions. Respondent was also required to pay a \$10,000 civil penalty. (State Exhibit 4)

The probationary terms and conditions set forth in Section I of the Stipulation and Consent Order pertained to the competency and billing allegations in the Statement of Charges. Respondent has been in compliance with those probationary conditions, which included but were not limited to: successful completion of a comprehensive clinical assessment, completion of a course of study at a college of dentistry, review of his clinical and billing practices by a Board approved practice monitor, successful completion of a Board approved recordkeeping course, successful completion of the Professional/Problem Based Ethics Program (PROBE), and successful completion of the Iowa dental jurisprudence examination. (State Exhibits 4, 26, 27; Respondent Exhibits B-E, I, J, K, L, N-R; Testimony of Richard Reay, D.D.S.; Respondent)

Respondent was enrolled in the PROBE program from May 15-17, 2009. The topics covered in the course included Infractions, Discipline and Sanctions; Clinician-Patient Models; Clinician-Patient Boundaries; and Accountability. Respondent received an "unconditional pass" for the course, which means that the candidate has made a qualified success of the effort and should be thought of as remediated and likely to recognize an ethical issue and likely to avoid transgression. (State Exhibits 26, 27; Respondent Exhibit B; Respondent testimony)

Section II of the Stipulation and Consent Order stated, in relevant part:

Since the time of the filing of the Notice of Hearing and Statement of Charges, the Board has received information alleging that Respondent has engaged in unprofessional and inappropriate conduct towards patients and staff members. To address these concerns, Respondent agrees to the following:..."

(State Exhibit 4, p. 5). Respondent made no admission with respect to inappropriate conduct and the Stipulation and Consent Order did not specify the nature of

Respondent's alleged unprofessional and inappropriate conduct.¹ Nevertheless, Respondent agreed to complete a Board approved professional boundaries course, to have a Board approved work site monitor who is present full-time in his office, and to have a Board approved work site monitoring plan. In addition, Respondent agreed to "in the future conduct himself in a professional manner towards patients and staff members." (State Exhibit 4, pp. 5-6)

Compliance With Section II of the Stipulation and Consent Order

Respondent completed a course entitled "Professional Boundaries in the Dentist-Patient Relationship" with John H. Hung, Ph.D., L.P. in Edina, Minnesota on May 5, 2009. Dr. Hung reviewed documents provided by the Board in order to tailor the course to Respondent's needs. Dr. Hung issued a report to the Board on May 10, 2009, outlining the scope and subject matter of the course. Dr. Hung concluded that Respondent had a satisfactory understanding of the core concepts related to professional boundaries in the dentist-patient relationship, including the nature of boundary violations, professionalism and societal expectations of the dentist role, standards of practice, fiduciary duty, sexual harassment, and the appearance of impropriety. Dr. Hung was reasonably satisfied that the course objectives had been met. (State Exhibit 25; Respondent Exhibit A)

The Board approved Respondent's Worksite Monitor Agreement. (Respondent Exhibit F) One of Respondent's full-time female employees (Staff #1) was designated as his Work Site Monitor and agreed to monitor Respondent's conduct towards patients and staff members and to report any inappropriate conduct to the Board. Staff #1 agreed to submit monthly reports to the Board for six months and thereafter to submit quarterly reports. The monthly report form required Staff #1 to check boxes indicating either that she had not witnessed any inappropriate or unprofessional behavior or that she had witnessed such behavior and to describe it. In each of the six monthly reports, Staff #1 indicated with a check mark that she had not witnessed inappropriate or unprofessional behavior. (Respondent Exhibit H; Testimony of Staff 1)

The quarterly reports had a different format than the monthly report. The quarterly report form required the Work Site Monitor to provide narrative answers to four

¹ The two former employees who made allegations of unprofessional conduct against Respondent in October 2008 testified at hearing in order to establish what information the Board or Board staff had in its possession prior to the Stipulation and Consent Order. Their allegations included, but were not limited to: calling employees insulting names; displaying a volatile mood in the office; exposing employees to pornography, exposing employees to sexually related material and dating websites on the personal computer in his office; and giving inappropriate compliments to young female patients.

specific questions. On January 15, 2010, Staff #1 attached a written narrative to her first quarterly report. Staff #1 wrote that she felt Respondent was incapable of changing his behavior because he did not think he was doing anything wrong and that if he did or said something inappropriate he would simply say that "The Board doesn't want him saying/doing that..." Staff #1 further reported that Respondent had just told a female patient who was in his operatory that he wanted to kiss her on the forehead, that the Board told him he was not supposed to and that's why he was in trouble with them. Respondent told the patient not to tell the Board and he laughed. According to Staff #1, the kiss on the forehead was not sexual and Respondent would kiss "young and old alike" on the forehead. (Respondent Exhibit H-7; State Exhibit 29; Testimony of Staff #1)

Staff #1 worked for Respondent for a number of years and loved her job. Respondent did not treat her as badly as other staff but she felt like she was "walking on eggshells" and Respondent had a volatile temper. She testified that she did not report her concerns about Respondent's behavior on the monthly reports because she was concerned about losing her job. However, when Staff #1 had to answer narrative questions on the quarterly report form she felt she had to disclose her concerns. Staff #1 subsequently resigned from her job on March 9, 2010.

At hearing, Staff #1 reported that Respondent continued to view dating websites on his office computer after he entered into the Stipulation and Consent Order with the Board. He also continued to call her names, like "dip stick" and "dink stick" in front of other staff and patients. Other staff also reported being called these same names. Staff #1 further reported that in addition to kissing patients on the forehead, Respondent also hugged patients and tickled patients, particularly children. One mother told Respondent, in front of Staff #1, to stop tickling her children. This comment was also heard and reported by other staff. Staff #1 also reported that Respondent continued to compliment female patients, particularly adolescent patients, on their appearance. She heard Respondent tell one adolescent boy that his sister (age 11 or 12) was a "future fox." This comment was also heard by other staff. Respondent told many patients about his problems with the Board. (Testimony of Staff #1, Staff #2, Staff#3)

A number of Respondent's current employees provided credible testimony describing Respondent's inappropriate behaviors and comments in the office. Staff #2 has been employed full time by Respondent since September 2007. Staff #3 has been employed full time by Respondent since November 2008. Both of them have observed Respondent viewing dating websites on his office computer during work hours in the past year. Staff #2 described the photographs on the websites as provocative but not pornographic. Recently Respondent has kept the door to his office shut and requires all

staff to knock on the door before entering to use the fax machine or speak to him. Staff #2 and Staff #3 have both observed Respondent kissing patients on the forehead and tickling patients, although he has now stopped doing so. Staff #2 has heard Respondent tell patients that he would like to tickle them or kiss them on the forehead but the Board told him that he couldn't. Staff #2 and #3 both reported that while they were driving to a seminar with Respondent he told them about his drug use and sexual conduct as a young man. In addition, both reported hearing Respondent comment that it would be great to go back to the caveman days when men could just club women who did not do what they want. Respondent made this comment to Staff #2 while a patient was present. Respondent made additional comments that Staff #2 felt were sexist and which offended her, including comments that women were only after men's money and women were only trying to make men miserable. (Testimony of Staff #2, Staff #3)

Staff #4 has worked two days a week in Respondent's office for more than 20 years. She has never seen pornography in his office and has never heard him make an inappropriately sexual comment to a patient. She has seen him touch or tickle patients but believes he only did so to make them feel more comfortable. She has not seen Respondent tickle patients in years. She has heard Respondent compliment patients on their appearance but not in a way she considered to be offensive. (Testimony of Staff #4)

Staff #5 has been working for Respondent three days a week since 1997. She has heard him compliment patients of both sexes and all ages. She has never seen pornography on his office computer but has seen the dating websites that he visits, and those websites did not offend her. (Testimony of Staff #5)

Staff #6 has worked at Respondent's office two days a week since October 2002. Staff #6 has heard Respondent compliment patients but has not heard Respondent make comments or advances that he considered inappropriate. Staff #6 has seen Respondent view dating websites on his office computer. (Testimony of Staff #6)

On February 3, 2010, the Board's investigator interviewed Respondent and some of his staff in follow-up to the January 2010 quarterly report. Respondent told the investigator that he no longer hugged patients unless they hug him first and denied making any inappropriate comments around patients. When asked if he continued to view inappropriate material on his office computer, Respondent answered that it "depends what you deem inappropriate." Respondent admitted that he continued to look at a Russian bride dating site and at a website called sugardaddy.com, which he described as similar to eharmony.com or any other dating site. Respondent told the investigator

that he took exception to anyone telling him what he can or cannot look at on the computer in his office. (Testimony of Brian Sedars; State Exhibit 28)

In the week prior to hearing, Board investigator Phil McCollum visited the two websites that Respondent admitted viewing on his office computer. Mr. McCollum created an account in order to get access to the site and requested information on women within a 100 mile radius. Mr. McCollum was able to view "non-private" photographs that showed women with partially exposed breasts and buttocks. Mr. McCollum printed representative pages from the website, which were submitted as exhibits. (Testimony of Phil McCollum; State Exhibit 33)

One of Respondent's former employees (Staff #7), who made allegations against him prior to the Stipulation and Consent Order, agreed to return to work for Respondent on a temporary basis shortly before the Board's hearing. Staff #7 reported that Respondent did call her a name (dink stick) after she returned to work for him. Staff #7 did not see anything inappropriate on Respondent's computer. (Testimony of Staff #7)

Four employees (Staff ##2, 3, 5, and 6) all reported that Respondent spoke to them a few weeks prior to the Board hearing. Three of the four essentially reported that Respondent told them to keep their mouths shut if they wanted to keep their jobs. They perceived Respondent's statement as a threat. Staff #5 only recalled being told to "be careful what you say" if you want the office to stay open. All of Respondent's employees were subpoenaed to testify.

Complaint Concerning Patient #1

Alleged Boundary Violations

On March 23, 2009 the United States Drug Enforcement Agency (DEA) office in Minneapolis sent a report to the Board, which stated that Respondent prescribed large amounts of a controlled substance (hydrocodone) to a female patient (Patient #1), gave the patient money, and lent her his car. The Board's investigator obtained law enforcement records as well as pharmacy and patient records for Patient #1. (State Exhibits 8-19) Board Investigator Phil McCollum and Investigator Brian Seders interviewed Respondent about Patient #1. Mr. Seders also spoke to Patient #1, the patient's mother, and the patient's in-laws. Neither the Board nor its staff had any information concerning Patient #1 prior to entering into the Stipulation and Consent Order with Respondent on February 23, 2009. (Testimony of Phil McCollum, Brian Seders; State Exhibits 6, 7)

Respondent first provided dental treatment for Patient #1 in his Garner dental office on December 8, 2008. It is unclear how Patient #1 became Respondent's patient. Respondent told Staff #1 that he met Patient #1 through sugardaddy.com. At one point, Respondent asked Staff #1 if she thought that Patient #1 (who was 23 years old) was too young for him. Staff #1 also reported that Respondent, referring to Patient #1, told her that he had found a "new mommy" for his daughter. Respondent, however, denies that he met Patient #1 through a dating website and claims that Patient #1 was referred to him at the Mason City emergency room because the ER staff knew his reputation for accepting Title XIX patients. Patient #1 presented at Respondent's office with severe dental problems, including multiple missing teeth, fractured teeth, infected teeth, and decaying teeth. Patient #1 told Respondent that she was in a lot of pain. (Testimony of Respondent; Staff #1; State Exhibits 18, 20)

Patient #1 also told Respondent that her physician suspected that her poor dental condition was caused by drug use. According to Respondent, the patient assured him and his staff that she was not a drug user and that the poor condition of her teeth was due to other circumstances. The patient told Respondent that she had lost a good job, her apartment, and her car in Minneapolis and that her fiancé, who is the father of her two children, was in jail. Patient #1 also told Respondent that it was difficult for her to meet people and to arrange play dates for her children. Respondent admits he told Patient #1 about his own personal problems and his difficulties arranging play dates for his daughter.

According to the patient record, Respondent saw Patient #1 in his dental office and provided dental treatment for her on December 8, December 9, December 17, December 18, December 23, 2008 and on January 9 and 11, 2009. Respondent gave Patient #1 prescriptions for pain medication (Lortab-25 tablets) on December 8, 11, 18, 23, 28, 2008 and on January 2, 9, 11, 18, 24, and 27, 2009. After he started her dental treatment, Respondent invited Patient #1 and her children to have pizza with him and his daughter at a local video arcade. Respondent was going through a contentious dissolution of marriage and had been advised by several friends that he should make arrangements for child care if he wanted to gain custody of his daughter. Respondent asked Patient #1 if she would be interested in a position as a live-in housekeeper/nanny if he got custody of his daughter. They agreed that she and her children would spend the night at his house to see how everyone got along. Patient #1 and her children spent one night in Respondent's home while his daughter was also there. Patient #1 and her children slept in separate bedrooms from Respondent. Respondent decided that a live-in situation would not work and subsequently lent the patient \$400 to use as a damage deposit and helped her look for her own apartment. (State Exhibit 18; Testimony of Respondent)

In January 2009, Patient #1 asked to borrow Respondent's Cadillac Escalade SUV to drive to Minnesota to visit her sister. Respondent agreed and also gave the patient \$100 for gas. The patient agreed to return the car in two days but failed to do so. When a week went by, Respondent called OnStar for assistance in locating his vehicle but was advised that they could not help him unless he filed a police report. One of Respondent's friends spoke to the patient's mother, who told him that the patient had decided to marry her fiancé, sell Respondent's car, and use the money to get him out of jail. Respondent testified that he filed a police report in Garner and then obtained the needed information from OnStar. Respondent was unable to recall which officer took the report. The Garner police chief told the Board's investigator that Respondent never filed a police report and that Respondent knows all of the officers in the Garner Police Department. Respondent eventually drove to Minneapolis with a friend to retrieve his car from Patient #1. (Testimony of Respondent)

Respondent continued to give Patient #1 Lortab prescriptions for at least two weeks while she was in Minnesota. Respondent did not see the patient in his dental office or during this time. The last prescription written by Respondent for Patient #1 was written on January 27, 2009, approximately one month before Respondent signed the Stipulation and Consent Order. (State Exhibit 18; Respondent Exhibit MM)

Patient #1 stayed with her fiancé's parents at least part of the time she was in Minnesota. The parents told the Board's investigator that they wondered why a dentist would lend Patient #1 his car and give her money for gas. The fiancé's father reported that he drove Patient #1 to the pharmacy several times so that she could fill prescriptions she received from Respondent. The fiancé's mother reported that she saw a text message that Patient #1 had written to Respondent which stated "you better give me what I need or I will turn you in for unprofessional conduct." Patient #1 told her fiancé's parents that Respondent was just a nice guy and they were not in a personal relationship. (Testimony of Brian Sedars; State Exhibit 6)

The Board's investigators interviewed Respondent at his dental office on May 6, 2009. Respondent had just returned from meeting with Dr. Hung in Minneapolis. After discussing his compliance with the Board order for approximately 30 minutes, the investigators presented a subpoena for the records of Patient #1. Respondent told them that he felt sorry for Patient #1 and let her borrow his car because he wanted her to be his live-in nanny. When the investigators began to question him about the prescriptions he wrote for Patient #1, Respondent began to perspire profusely and had to excuse himself to get a towel. Respondent suggested at hearing that he was on a new medication that caused profuse sweating, but he never submitted any verification of the

prescription. Respondent told the investigators that he wired the patient \$400 for an apartment in Minnesota, even though she had not returned his vehicle, because he thought she would come back to Iowa and be his nanny. (Testimony of Brian Sedars; Phil McCollum; State Exhibits 6, 7)

Brian Sedars spoke to Patient #1 by phone on May 28, 2009 while she was at her mother's home. Patient #1 told Mr. Sedars that Respondent "threw" money at her, made her feel uncomfortable, and offered her \$500 a week to be his live-in nanny. Patient #1 denied that there was a romantic relationship between them but she stated she believed that Respondent wanted a romantic relationship. She also stated that all of the prescriptions were provided for pain related to her dental work. (Testimony of Brian Sedars; State Exhibit 6)

Respondent provided the Board with a written explanation of his interactions with Patient #1. Respondent wrote that although his interactions with the patient may seem highly unusual, they are characteristic of his past interactions with patients. Respondent wrote that over the past 25 years he has loaned his car and money to other patients and has allowed patients to stay at his house or in his rental duplex rent free. He provided other examples of bartering dental work in exchange for laundry or cleaning services and providing free lodging to persons in exchange for other bartered services. (State Exhibit 20; Testimony of Respondent)

Alleged Prescription Writing Violations

From December 8, 2008 through January 27, 2009, Respondent wrote Patient #1 eleven prescriptions for 25 tablets of Lortab (hydrocodone) for a total of 275 tablets. Three of the prescriptions were not documented in the patient's record. Respondent and his staff all testified that when Respondent issues a prescription to the patient, the staff member who fills out the patient information on the prescription is supposed to document it in the patient record. If the prescription is called into the pharmacy, the staff person who calls in the prescription is responsible for charting it. If Respondent authorizes a prescription over the phone, he must tell staff about the prescription so that they can document it in the patient record. (Respondent testimony; Patient ##1, 3, 4, 5, 6, 7; State Exhibit 36; Respondent Exhibit MM)

- At her first dental visit on December 8, 2008, Respondent prescribed antibiotic and 25 tablets of Lortab (hydrocodone) 7.5/500 mg for Patient #1. The prescriptions are documented in the patient's record. (State Exhibits 18, 20; 36; Testimony of Respondent)

- Patient #1 returned to Respondent's office the following day (December 9, 2008) and Respondent opened up teeth ##7, 8, and 10, reamed the canals, placed FMC pellets and cavits, and then placed a white filling in tooth #9. On December 11, 2008, the patient called Respondent's office and reported that she had left her overnight bag containing her medication in a Rochester motel. Respondent wrote new prescriptions for the antibiotic and the Lortab, and these prescriptions are documented in the patient record. (State Exhibits 13, 18, 19; 36)
- On December 17, 2008, Respondent performed root canals, crown preparation, and placed temporary crowns on teeth ## 7 and 10. On December 18, 2008; Patient #1 reported terrible pain in tooth #8, and Respondent performed a root canal. (State Exhibits 18, 19) The patient's pharmacy records show that Respondent provided the patient another prescription for 25 Lortab tablets, which she filled at an Iowa pharmacy. (State Exhibit 13) However, this prescription is not documented in the patient record. (State Exhibit 18; 36)
- On December 23, 2008, Respondent performed a root canal on tooth #9 and again prescribed the patient an antibiotic and Lortab tablets. The prescriptions are documented in the record but the number of Lortab tablets is not recorded. (State Exhibit 18; 36) The patient filled the prescription for 25 Lortab tablets at an Iowa pharmacy. (State Exhibit 13)
- On December 28, 2008, Respondent again prescribed an antibiotic and 25 tablets of Lortab for the patient. The prescriptions are documented in the patient record but no reason is given for issuing the prescriptions. The patient was not seen in Respondent's office that day. (State Exhibit 18; 36) The patient filled the Lortab prescription at an Iowa pharmacy. (State Exhibit 13)
- On January 2, 2009, Patient #1 filled a prescription at a Minnesota pharmacy for 25 tablets of Lortab. (State Exhibit 14). The patient was not seen in Respondent's office on that day and the prescription was not documented in the patient record. (State Exhibit 18) Respondent recalls that he was at home when the patient called him from Minnesota and reported that she was in a lot of pain and unable to get in to see another dentist. Respondent admits that he probably forgot to report this prescription to his staff when he returned to the office. (Respondent testimony)
- Respondent documented that the patient presented at his office on January 9, 2009, with a large swelling to the buccal of tooth #9. Respondent incised and drained the tooth to remove the infection and provided additional prescriptions for an antibiotic and for 25 tablets of Lortab. The prescriptions were documented in the patient record. (Exhibit 18). The patient filled a Lortab prescription at an Iowa pharmacy on January 7, 2009 but did not fill any prescription with a date of January 9, 2009. (State Exhibit 13) The Board's investigators included the January 7, 2009 prescription on the list of prescriptions that were not documented in

Respondent's records. (State Exhibit 36) However, Respondent testified at hearing that he believes he entered the wrong date on the patient's chart and believes that he actually treated Patient #1 on January 7 not January 9. The Board accepted Respondent's explanation for this discrepancy in the records.

- On January 12, 2009 Respondent authorized another prescription for 25 tablets of Lortab for Patient #1, which she filled at a Minnesota pharmacy. Respondent did not document the prescription in the patient record. Respondent had seen the patient in his office on January 11, 2009 to recement her temporary crown and noted that the patient was still too swollen to place the permanent crown for teeth ## 7 and 10.
- On January 18, 2009 Respondent received a telephone call from the patient, who was still in Minnesota. Respondent documented the phone call in the patient record. The patient reported that she still had painful swelling in the buccal fold area. Respondent explained to the patient that he had given her "about all the pain pills that we legally could for 1 problem." Respondent told Patient #1 that she needed to come in for an x-ray and for referral to an oral surgeon. The patient said she would come into the office as soon as possible. Respondent authorized another 25 Lortab tablets and documented the prescription in the record.
- On January 20, 2009, Respondent sent a referral letter and the patient's x-rays to an oral surgeon, but the patient was not evaluated by the oral surgeon until April 6, 2009.
- On January 24, 2009, Patient #1 called Respondent from Minneapolis and told him that she was still having pain but was unable to get to Mason City to see the oral surgeon. Respondent authorized another prescription for 25 tablets of Lortab, which the patient filled at a Minnesota pharmacy.
- On January 27, 2009, Respondent prescribed another 25 tablets of Lortab for Patient #1, and the prescription was filled at a Minnesota pharmacy. Respondent documented the prescription in the record and also wrote that he told the patient by text message that she needs to see an oral surgeon.
- Respondent saw the patient for the last time on April 2, 2009 when he seated the crowns for teeth ##7 and 10.

(State Exhibits 18, 19, 36; Respondent Exhibit MM)

An Iowa licensed oral surgeon reviewed the pharmacy records and Respondent's patient record for Patient #1. The oral surgeon concluded that Respondent's prescriptions for Hydrocodone (Lortab) and Amoxicillin were reasonable and within the standard of care based on the documented treatment, the clinical findings, the diagnosis, and the length of time to complete the patient's treatment. In his opinion,

the amount and quantity of prescriptions did not appear excessive based on the patient's course of treatment and presenting problems. (State Exhibit GG)

BMI Evaluation

On July 7, 2009, the Board issued an Evaluation Order that required Respondent to schedule a complete psychological, psychiatric, and professional boundaries evaluation through Behavioral Medicine Institute (BMI) of Atlanta. (State Exhibit 22) Respondent completed the evaluation on September 2, 2009. BMI administered a number of psychological tests to Respondent, including a polygraph examination. Respondent was screened for drugs and substances. BMI also obtained information from the Board, from Respondent, and from three of Respondent's employees. BMI issued a written report on September 18, 2009. (State Exhibit 23)

BMI found no evidence that Respondent was abusing drugs or alcohol, no evidence that Respondent was engaging in sexual behavior with patients, and no evidence that Respondent was trading dental care for favors. However, BMI did conclude that despite completing two boundary courses, Respondent had not changed his behavior or the way he runs his practice. BMI concluded that Respondent continued to engage in sexually harassing behavior, continued to call staff names, and continued to view pornography in his office. BMI described Respondent's sexually harassing behavior as an Occupational Disorder, which it described as a condition requiring clinical attention. BMI further found that Respondent had many symptoms of someone with Narcissistic Personality Disorder, but did not confirm a diagnosis.

BMI made a number of recommendations with respect to Respondent's future practice, including that Respondent:

- Should be required to have Specter Pro or Net Nanny installed on any computer in the office to ensure that there is no risk of any patient seeing any pornography on Respondent's computer.
- Should be required to discontinue personal use of his office computer and all personal items should be moved to Respondent's personal computer at home.
- Should be required to have all patients in a one week interval, once per month, complete a Patient Satisfaction form and return the completed forms to the Board.
- Should be required to have four staff members complete a Staff Surveillance Form, once per month, and provide the completed forms to the Board.
- Should be required to immediately discontinue bartering services with dental patients.

- Should obtain clarification from the Board of the legality of providing free dental services to friends.
- Should be required to meet with Dr. Hung on a regular basis. Dr. Hung should be provided the results from the monthly staff reports, tracking software reports, and patient satisfaction reports.

The BMI report was signed by Gene G. Abel, M.D., Markus Wiegel, Ph.D., and Sarah Gregg, R.N., C.A.R.N. (State Exhibits 23, 31)

Dr. Abel owns BMI and has evaluated approximately 550 individuals for professional sexual misconduct. Dr. Abel's deposition was taken by video conference on March 22, 2010. After learning that Respondent had not removed the dating websites from his office computer and continued to make inappropriate comments to staff, Dr. Abel added the additional recommendation that Respondent should only be allowed to work with another dentist with whom he shares staff. (State Exhibit 32, pp. 4-5, 34-38)

CONCLUSIONS OF LAW

Count I – Unprofessional Conduct

Iowa Code section 153.34(7)(2009) authorizes the Board to discipline a licensed dentist, including issuance of a civil penalty not to exceed \$10,000, for dishonorable or unprofessional conduct in the practice of dentistry. 650 IAC 27.9(1) provides that licensee actions determined by the Board to be abusive, coercive, intimidating, harassing, untruthful or threatening in connection with the practice of dentistry shall constitute unethical or unprofessional conduct.

The preponderance of the evidence established that Respondent committed unprofessional conduct in the practice of dentistry towards patients and staff, in violation of Iowa Code section 153.34(7). After signing the Stipulation and Consent Order and even after attending Dr. Hung's course on professional boundaries, Respondent continued to view dating websites on his office computer in the presence of his mostly female staff. These dating websites included sexually provocative photographs of women. Respondent also shared inappropriate personal information with staff members. In addition, Respondent continued to call female staff insulting names and to make inappropriate comments in the presence of staff. Respondent warned four of his staff, just weeks prior to his hearing, that they should be careful about what they said at hearing if they wanted to keep their jobs. Regardless of Respondent's intent in making the statements, several staff members reasonably

interpreted the statements as a threat that they would lose their jobs if they provide testimony that was adverse to Respondent.

In his Trial Brief, Respondent cites to federal case law defining the legal standard for establishing a hostile work environment based on sexual harassment in an employment discrimination case. In determining what behavior constitutes unprofessional conduct by licensed dentists under its statutes and rules, the Board is not bound by the legal standards concerning employment discrimination. The Board is authorized to discipline dentists for inappropriate comments and behavior with staff even if the dentist would not be civilly liable for that same behavior in a sexual harassment or hostile work environment lawsuit.

Respondent failed to maintain appropriate professional boundaries with some patients even after he completed the professional boundaries course with Dr. Hung. Although it is not inappropriate for a dentist to appropriately compliment a patient on their appearance, Respondent excessively and inappropriately commented on the appearance of young female patients. It was inappropriate for Respondent to repeatedly tickle children and to kiss patients on the forehead. It was inappropriate for Respondent to tell patients that he wanted to hug or kiss them but that the Board would not allow it.

Respondent also established inappropriately personal relationships with patients by loaning them money and his car and by bartering for dental services. During the professional boundaries course, Dr. Hung reviewed the problems inherent in such relationships with patients, including the inherently uneven distribution of power in the dentist-patient and dentist-staff relationship, the vulnerability of patients and staff, possible misuse of power by the dentist, and the importance of the perception/appearance of impropriety. (See State Exhibit 25) There is also potential conflict of interest if Respondent and the patient place different values on the services provided. Even after completing the course, Respondent failed to recognize or appreciate the ethical implications of these relationships and appeared to view them merely as acts of kindness.

Finally, Respondent's relationship with Patient #1 clearly constituted unprofessional conduct in the practice of dentistry. Respondent failed to maintain appropriate professional boundaries when he solicited this 23 year old female patient as a live-in nanny, when he invited her and her children to spend the night at his home, and when he lent her significant sums of money and his car for an out-of-state trip. As the patient's treating dentist, Respondent had disproportionate power in the relationship even before he gave the patient money and lent her his car. The patient was dependent

on Respondent for extensive dental treatment and for pain medications. Although the evidence did not establish that Respondent had an intimate or romantic relationship with Patient #1, both Respondent's behavior and the comments he made to Staff #1 about the patient demonstrated that Respondent was interested in more than just a professional relationship with the patient.

The number, frequency, and circumstances of Respondent's Lortab prescriptions for Patient #1 also raise serious concerns, particularly when Respondent had reason to question whether the patient was seeking drugs. At her first visit, the patient told Respondent that at least one physician suspected that her dental problems were caused by drug use. Respondent knew that the patient's fiancé was in jail in Minnesota for a drug related conviction. The patient made multiple requests for additional medication, reported losing medication and requested its replacement, and repeatedly asked for prescriptions to be called to a Minnesota pharmacy. These circumstances should have prompted Respondent to exercise extra caution in providing the patient multiple prescriptions for controlled substances.

The evidence failed to establish that the number or frequency of Lortab prescriptions provided for Patient #1 violated the standard of care, in light of her severe dental problems and the documented dental treatment that she received. (Respondent Exhibit GG) Nevertheless, it appears likely that Respondent's inappropriately personal relationship with Patient #1 interfered with his ability to exercise independent professional judgment in evaluating her requests for pain medications.

Respondent's professional and personal relationship with Patient #1 took place in December 2008 and January 2009, which was prior to the Stipulation and Consent Order. In his Trial Brief, Respondent argues that the legal doctrine of claim preclusion should be applied to prevent the Board from disciplining Respondent for any acts of professional misconduct that occurred prior to the February 23, 2009 Stipulation and Consent Order. The doctrine of claim preclusion bars further litigation of a claim following a final adjudication or judgment on the merits. *In re Marriage of Ginsburg*, 750 N.W.2d 520, 522 (Iowa 2008). A party must litigate all matters growing out of the claim, and claim preclusion will apply not only to matters actually determined in an earlier action but to all relevant matters that could have been determined. *Id.* However, the Stipulation and Consent Order provided that it was resolving "...any charges that could be brought forth by the Board, based on any current information in possession of the Iowa Dental Board, its agents, investigators, or employees..." (State Exhibit 4, p. 1) Neither the Board nor its staff had any information about Respondent's relationship with Patient #1 until after the Stipulation and Consent Order was signed. Therefore this

claim of professional misconduct could not and was not determined by the entry of the Stipulation and Consent Order.

Count II - Failure To Record Prescriptions in the Dental Record

Iowa Code section 153.34(4) (2009) authorizes the Board to discipline a licensed dentist for willful or repeated violations of Board rules. 650 IAC 16.2(3) requires the dentist, on each occasion when a medication is prescribed, administered, or dispensed to a patient, to make an entry in the patient's dental record containing the following information: the name, quantity, and strength of the medication; directions for its use; the date of issuance; and the condition for which the medication was used.

Respondent's patient record clearly does not contain all of the required entries for the prescriptions that he provided to Patient #1. At least three prescriptions were not documented in the patient chart, one prescription did not have the number of tablets recorded, and several prescriptions do not contain the directions for use. Nevertheless, these record-keeping deficiencies do not warrant a separate finding of violation. Although Respondent is ultimately responsible for ensuring that his patient records are complete, it does appear that Respondent's staff may have failed to make some of the entries consistent with established office procedures. In addition, Respondent completed a Board approved record keeping course after these errors occurred. The completion of the record-keeping course adequately addresses these errors.

Count III - Failure to Comply With Board Decision Imposing Discipline

Iowa Code section 153.34(4) (2009) authorizes the Board to discipline a licensed dentist for willful or repeated violations of Board rules. 650 IAC 30.4(23) authorizes the Board to discipline a licensed dentist for failure to comply with a decision of the board imposing discipline. The February 23, 2009 Stipulation and Consent Order required Respondent to "in the future conduct himself in a professional manner towards patients and staff members." (State Exhibit 4, p. 6) As discussed in connection with Count I, Respondent continued to act in an unprofessional manner towards patients and staff following the Stipulation and Consent Order. Respondent has therefore violated Iowa Code section 153.34(4)(2009) and 650 IAC 30.4(23).

DECISION AND ORDER

THEREFORE, IT IS HEREBY ORDERED that Respondent's license to practice dentistry in the state of Iowa shall be immediately **SUSPENDED** for a period of seven (7) consecutive working days effective upon receipt of this Order. Following the period

of suspension the Respondent's dental license shall be placed on indefinite probation subject to the following terms and conditions:

1. The Respondent shall remit a civil penalty in the amount of five thousand (\$5,000.00) dollars within sixty (60) days of the date of the Order.
2. The Respondent shall be required to maintain a Board approved software internet filter on all computers in his dental office to ensure that Respondent in not accessing pornographic material.
3. The personal use of the computer at the office shall be discontinued and all personal items on the computer should be moved to Respondent's private computer in his home.
4. The Respondent shall not engage in unprofessional behavior or inappropriate physical contact with patients and staff persons, i.e. tickling, hugging, kissing.
5. The Respondent shall not engage in unprofessional verbal comments with staff persons or patients, i.e. name calling, inappropriate comments/compliments on physical appearance, lewd remarks.
6. Respondent shall post a copy of the Board approved Principles of Dental Practices and Ethics in the reception area of his dental office and in any operatory in which he sees patients.
7. The Respondent shall on a quarterly basis, have all patients that he treats during a one week period complete a Board approved Patient Satisfaction Survey. Respondent shall designate a staff person who will be contacted by the Board each quarter to distribute patient satisfaction surveys to all patients for a one week period as selected by the Board. The office staff person will ensure that all surveys are distributed to these selected patients with postage paid envelopes to be forwarded directly to the Board. Respondent shall not have access to these completed forms.
8. The Respondent shall require his staff members to complete a staff surveillance form, approved by the Board, which shall be independently forwarded to the Dental Board by each staff person on a monthly basis. Respondent shall not have access to these completed forms.

9. Respondent shall not barter dental work for other kinds of work or services by his dental patients so that there is no blur of the boundary between patient and dentist.

10. Respondent shall on a monthly basis meet with Dr. Hung for follow up concerning professional boundaries issues for a period of six (6) months. Following this six (6) month period, Respondent shall meet at a frequency determined by Dr. Hung. Dr. Hung shall report directly to the Board following each meeting.

11. Respondent shall within ninety (90) days of the date of this Order, return to the Behavioral Medicine Institute (BMI) of Atlanta, Georgia, for follow up assessment. The Board shall forward to BMI prior to assessment all information related to the hearing and information related to compliance with all Orders of the Board.

- a. Respondent shall immediately comply with all recommendations made by BMI as a result of this assessment.
- b. Respondent shall report to the Board in writing following completion of the assessment, a written plan detailing how he plans to implement the practice recommendations made by BMI.
- c. Respondent shall sign the necessary releases to allow the free flow of information between the Board and BMI.
- d. Respondent shall ensure that a complete copy of the assessment is forwarded directly to the Board by BMI.

12. Respondent shall submit quarterly written reports on the form provided by the Board on or before the first day of January, April, July and October of each calendar year detailing his compliance with all of the terms of this Order and any subsequent Board Order related to this matter as well as a personal statement as to his progress.

13. Respondent shall fully cooperate with random unannounced visits by agents of the Board.

14. Respondent shall fully disclose this Order to all current and future licensees, employees and/or employers. Respondent shall report back to the Board with signed statements from all such licensees, employees and employers within fourteen (14) days of any new employment relationship, indicating that they have read the Notice of Hearing and Statement of Charges, and this Order, and understand the current terms and conditions placed on Respondent's dental

license. All employees shall report any concerns directly to the Board without adverse employment consequences.

15. Respondent shall be responsible for all costs associated with compliance with this Order.

16. Respondent shall upon reasonable notice, and subject to the provisions of 650 Iowa Administrative Code 31.6 appear before the Board at the time and place designated by the Board.

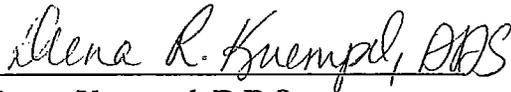
17. Periods of residence or practice outside of the state of Iowa shall not apply to the duration of this Order unless Respondent obtains prior written approval from the Board. Periods in which Respondent does not practice dentistry and/or he fails to comply with the terms established in this Order shall not apply to the duration of this Order unless Respondent obtains prior written approval from the Board within fourteen (14) days of the change.

18. Notice of any change of practice location must be provided to the Board within fourteen (14) days.

These terms and conditions are in addition to the terms and conditions set forth in the Board's February 23, 2009, Stipulation and Consent Order, which shall remain in full force and effect.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 650 IAC 51.35(2) that the Respondent shall pay \$75.00 for fees associated with the disciplinary hearing and any costs calculated by the executive director within thirty (30) days of receipt of the notice of costs.

Dated this ^{29th} day of *April*, 2010.



Deena Kuempel, D.D.S.

Chairperson

Iowa Dental Board

cc: Theresa O'Connell Weeg
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Judicial review of the board's decision may be sought in accordance with the terms of Iowa Code chapter 17A and Iowa Code section 153.33(5)(g) and (h).