

BEFORE THE IOWA DENTAL BOARD

IN THE MATTER OF:

JAY R. BUCKLEY, D.D.S.

RESPONDENT

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
DECISION AND ORDER**

On October 23, 2015, the Iowa Dental Board (Board) filed a Notice of Hearing and Statement of Charges against Jay R. Buckley, D.D.S. (Respondent), which alleged the following three counts:

Count I: Failure to maintain a satisfactory standard of competency in the practice of dentistry, in violation of Iowa Code section 153.34(8) and 650 IAC 30.4(16);

Count II: Failure to maintain patient records in a manner consistent with the protection of the welfare of the patient, in violation of Iowa Code section 153.34(8) and 650 IAC 27.11; and

Count III: Failure to comply with a decision of the Board imposing licensee discipline, in violation of Iowa Code section 272C.3(2)(a) and 650 IAC 30.4(23).

The hearing was held before the Board on January 29, 2016 and April 28, 2016 in the Board's Conference Room at 400 SW 8th Street, Des Moines, Iowa. The following members of the Board presided at the hearing: Steve Bradley, D.D.S., Chairperson; Steven Fuller, D.D.S.; Thomas Jeneary, D.D.S.; Kaaren Vargas, D.D.S.; William G. McBride, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier and Lori Elmitt, Public Members. Respondent appeared and was represented by attorneys Steven P. Wandro, Terry Gibson, and Brian Lalor. Assistant Attorney General Sara Scott represented the state. 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). Following the hearing, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f)(2015), to deliberate their decision. The Board directed the administrative law judge to draft their Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the testimony of Brian Sedars, Dee Ann Argo, MC, John Campbell, D.D.S., and Respondent. The record also includes State Exhibits A-HH (See Exhibit Index for description) and Respondent Exhibits 1-12, 14-19, 21-22, 29, and 37. The record also includes Respondent's Answer, Notice of Prehearing Conference, State's Objections to Respondent's Exhibits, Respondent's Response to State's Objections to Respondent's Exhibits, Ruling on State's Objections, and Order Rescheduling Hearing.

FINDINGS OF FACT

Respondent's Practice and Disciplinary History

Respondent was issued Iowa dental license number 6782 on July 1, 1982. Respondent's license is current and will expire on August 31, 2016. Respondent practices as a general dentist from his dental office in Des Moines, Iowa. In the past, a significant portion of Respondent's practice was providing dental care to nursing home patients using mobile dental units. Respondent estimates that from 2000-2013, nursing home patients comprised approximately 40% of his practice. As of March 2016, Respondent was no longer treating nursing home patients. Respondent has never employed a dental hygienist, and he performs all prophylaxis and periodontal procedures himself. Respondent also takes all of his own x-rays. (Respondent testimony; State Exhibits A, C)

Respondent has the following disciplinary history with this Board:

a. On December 1, 1999, Respondent was charged with failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry and unprofessional conduct based on a failure to fully explain his treatment regimen and failure to obtain patient authorization before beginning treatment. The charges were filed after a Board-appointed peer review committee reviewed the care that Respondent had provided to four patients. (State Exhibit EE-a)

On February 16, 2000, Respondent and the Board entered into a Stipulation and Consent Order to resolve these charges. Respondent's license was placed on probation for five years, and Respondent agreed to undergo a comprehensive clinical assessment by a college of dentistry. (State Exhibit EE-b)

Following a two day clinical assessment, the University of Illinois-Chicago College of Dentistry issued a written assessment report on May 25, 2000. Although the assessment report concluded that Respondent had excellent knowledge in most areas, it identified

several areas of concern in his record documentation. These concerns included, but were not limited to: incomplete charting of examination findings, chart entries that did not adequately describe treatment provided or efforts to inform patient of treatment options, lack of explanation of refusal of suggested treatment and explanation of possible consequences of refusal or choice of alternate treatment, and inconsistency in periodontal screening and documentation of diagnosis. The assessment report recommended that Respondent engage in home study followed by a course at the dental college. On February 16, 2005, Respondent was released from probation. (State Exhibits DD; EE-c)

b. On August 28, 2008, Respondent was charged with obtaining a fee by fraud or misrepresentation and with failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control. It was alleged, in part, that Respondent was not sterilizing all dental hand pieces between patients. (State Exhibit FF-a)

On April 15, 2009, Respondent and the Board entered into a Stipulation and Consent Order to resolve these charges. Respondent was required to pay a civil penalty of \$1,000 and his dental license was placed on probation for a period of two years. Respondent was required to have a Board approved written office protocol for infection control and to submit to random practice reviews by Board consultants to ensure that he was complying with the approved written protocol. (State Exhibit FF-b)

c. On February 2, 2013, Respondent was again charged with failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infections control. Respondent was also charged with failing to maintain sanitary conditions in his dental office by not properly sterilizing hand pieces. (State Exhibit GG-a)

An evidentiary hearing was held before the Board on May 10, 2013. On July 2, 2013, the Board issued its Findings of Fact, Conclusions of Law, Decision and Order, which found that Respondent repeatedly and willfully failed to maintain safety and sanitary conditions in his dental office and failed to comply with standard precautions for preventing and controlling infectious diseases. The evidence presented by the state included testimony from Health Professions Investigator Brian Sedars and from two of Respondent's employees, as well as 19 exhibits. The Board placed Respondent's dental license on probation for a period of five (5) years and required him to:

- within sixty (60) days and annually thereafter, retain the services of an outside Infection Control Trainer, approved by the Board, to provide infection control

training to Respondent and his staff. Respondent was required to provide written verification to the Board that the required training was conducted;

- within sixty (60) days, enter into a written monitoring agreement with another licensed dentist, approved by the Board, to serve as Respondent's Practice Monitor for infection control. The Practice Monitor was required to randomly visit Respondent's dental office in order to review Respondent's procedures for sanitation and infection control and to review his compliance with the CDC recommendations or requirements for standard precautions to prevent and control infectious diseases. The Practice Monitor was required to utilize the OSAP/CDC checklist during the random visits and to provide quarterly written reports to the Board no later than the first day of January, April, July and October of each calendar year of probation;
- to submit quarterly written reports to the Board no later than 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
- to pay a \$5,000 civil penalty and a \$75.00 hearing fee within 30 days. (State Exhibit GG-b)

Respondent filed a Petition for Judicial Review of the Board's Decision. On July 8, 2014, the Board's Decision was affirmed in Polk County District Court. (State Exhibit GG-c). Respondent filed an appeal with the Iowa Supreme Court but voluntarily dismissed this appeal on October 7, 2014. (State Exhibit GG-d)

Respondent's Failure to Comply with the Board's July 2, 2013 Decision and Order

Brian Sedars was employed as the Board's Health Professions Investigator for eight years. Sedars was assigned as Respondent's probation manager after the Board issued its July 2, 2013 Decision and Order, and he knew that Respondent had appealed the Board's decision to the district court. On multiple occasions, Respondent and/or Respondent's wife, who was his receptionist, told Sedars that they disagreed with the Board's findings and that they believed that Respondent was being treated unfairly. They never asked Sedars to take their concerns to the Board. If they had, Sedars would have told them to file a written request with the Board. This is what Sedars has told other licensees who have requested changes to Board orders. Sedars never told Respondent that he was excused from complying with the Board's July 2, 2013 Decision and Order. (Sedars, Respondent testimony)

In August 2015, Sedars called Respondent to ask if he had complied with any of the terms of the Board's July 2, 2013 Decision and Order. Respondent told Sedars that he had not complied because he had appealed the Board's Order and because he did not agree with

it. Respondent also told Sedars that the decision was based on lies, that the Board had treated him unfairly, and that he would not be complying with the Board's Order. Respondent does not deny making these statements to Sedars, but he testified that Sedars caught him "by surprise." Sedars left the Board's employment in November 2015 and has had no further communication with Respondent since then. (Sedars, Respondent testimony; State Exhibit D, pp. 2-3)

As of April 28, 2016, Respondent had not taken any steps to comply with the terms of the Board's July 2, 2013 Decision and Order. Respondent has not paid the \$5,000 fine or the \$75.00 hearing fee. Respondent has not retained the services of an outside Infection Control trainer and has not provided written verification to the Board that the required training was conducted. Respondent has not entered into a written agreement with another Board approved licensed dentist to serve as his Practice Monitor for sanitation and infection control procedures. Respondent has not submitted any quarterly reports. (Testimony of Brian Sedars, Respondent)

In January 2013, which was prior to the issuance of the Board's Decision and Order, Respondent placed a newly hired employee in charge of infection control for his office. Respondent testified that this employee previously taught infection control to dental assistant students at Des Moines Area Community College. Respondent has never asked the Board to approve this employee as the infection control trainer for his practice, and he has not submitted any verification of the annual infection control training that he and his staff have completed. (Respondent testimony)

Respondent testified that he was waiting to comply until after Sedars presented his contentions to the Board that his disgruntled former employee had given perjured testimony at his disciplinary hearing. Respondent further testified that the same employee later brought a civil action against him and provided testimony in District Court that was different from the testimony she gave before the Board.¹ Respondent never obtained a stay of the Board's July 2, 2013 Decision and Order. Respondent admits that he never received any correspondence from the Board informing him that he did not have to comply. (Respondent, Sedars testimony)

¹ Attorney Steven Wandro made a professional statement concerning his prior representation of Respondent before the Board and in this civil case. Mr. Wandro stated that the state's principal witness at Respondent's disciplinary hearing before the Board (Pam Gibson) later sued Respondent for wrongful termination, but a jury ruled in favor of Respondent and did not grant Gibson reinstatement or damages. (Professional Statement of Steven Wandro)

Complaint Filed by MC and Subsequent Investigation and Record Review

On December 9, 2013, the Board received a complaint from MC, who had been Respondent's patient from July 1999 until June 2013. MC became concerned about his dental health after reading a newspaper article about the Board's July 2, 2013 disciplinary order. On August 14, 2013, MC saw another general dentist, Kenton Gleichman, D.D.S., in order to get a second opinion. After performing a comprehensive examination, including full mouth periodontal probing and a full mouth series of x-rays, Dr. Gleichman informed MC that he had advanced gum and bone disease. According to MC, Respondent had always verbally assured him that his dental health was excellent. (Sedars, MC testimony; State Exhibits E, F, G)

After receiving MC's complaint, the Board subpoenaed Dr. Gleichman's records and asked him to provide a report of his findings. Dr. Gleichman's December 27, 2013 response to the Board states that he diagnosed MC with moderate to advanced type III periodontal disease. MC showed "heavy calculus and plaque throughout" and moderate pocket depths, especially in the posterior teeth. Dr. Gleichman also found decay under a previous crown on tooth number 31 and decay on tooth number 18. (State Exhibits D, G; Sedars testimony)

Dr. Gleichman referred MC to periodontist Thomas A. Statz, D.D.S. for further evaluation and treatment. On September 4, 2013, Dr. Statz conducted a complete periodontal examination of MC and then provided a report of his findings to Dr. Gleichman. Dr. Statz diagnosed MC with Generalized Advanced Chronic Periodontitis, Recession, and Caries. Dr. Statz reported clinical attachment loss ranging from 3-10+ mm, probing depths ranging from 3-9+ mm, furcation² involvement on all molars, and poor oral hygiene. Dr. Statz recommended that MC have full mouth scaling and root planing and a systemic antibiotic regimen, followed by surgical therapy as needed. Dr. Statz further recommended that when MC's periodontal condition became stable, he should have periodontal maintenance appointments with Dr. Gleichman every three months. Dr. Statz's report further stated that the prognosis for teeth ##2, 3, 14, 15, 18, 19, 30, and 31 was poor, and the prognosis for teeth ##1, 16, 17, and 32 was hopeless. The Board subpoenaed a copy of Dr. Statz's dental records. (States Exhibits D, H; Sedars testimony)

The Board also subpoenaed Respondent's dental records for MC. (State Exhibit F) When Brian Sedars picked up those records, Respondent told him that MC had a lot of calculus and inflammation but no major bone loss. Respondent also told Sedars that he provided

² Furcation is when the bone level gets so low that it is between where the teeth root splits. The long term prognosis for the tooth is greatly compromised. (Dr. Campbell testimony)

MC with root planing and scaling every six months at no charge because MC was a friend. Respondent also told Sedars that he did not have any patients on 3 month periodontal recalls. (Sedars testimony; State Exhibit D)

After the Board reviewed MC's complaint and dental records, Sedars was directed to subpoena additional adult periodontal patient records from Respondent. Sedars obtained a list of Respondent's periodontal billings from Iowa Medicaid Enterprise (IME), and from this list he randomly selected 18 additional periodontal patient records. (Sedars testimony; State Exhibits D, K)

Board Consultant's Review of Patient Records

Standard of Care. The periodontal treatment records for MC and for the additional 18 patients were submitted to John Campbell, D.D.S. Dr. Campbell was asked to review whether Respondent's periodontal treatment of these patients met the standard of care. Dr. Campbell is a general dentist who has had a solo dental practice in Des Moines, Iowa since 1987. Dr. Campbell provides periodontal diagnosis, treatment planning, and treatment in his dental practice. He has provided dental treatment in long term care facilities and to Medicaid patients. Dr. Campbell has served as a case reviewer for the Board since 1995, and he has also testified in other court cases. (Dr. Campbell testimony; State Exhibits X, Y)

Dr. Campbell's knowledge of the standard of care is based on his clinical training, his review of research articles and journals, and his consultations with the dental schools at the University of Iowa and Creighton University. For the standard of care in periodontal screening, diagnosis and treatment, Dr. Campbell also reviewed and relied on several articles published by the American College of Periodontology, which is the highest governing entity for periodontal care. These include the "Parameter on Comprehensive Periodontal Examination," published in May 2000; "Parameter of Periodontal Maintenance," published in May 2000; "Diagnosis of Periodontal Diseases," published in August 2003; and "Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology," published in July 2011. (Dr. Campbell testimony; State Exhibit CC)

In his testimony at hearing, Dr. Campbell addressed and explained the standard of care for the evaluation of the patient, the diagnosis of periodontal disease, the development and communication of an appropriate treatment plan, appropriate periodontal treatment, periodontal maintenance care, and necessary documentation. Dr. Campbell explained that the periodontal screening record (PSR) is a tool used to initially screen patients for periodontal disease. The PSR divides the patient's mouth into sextants. The dentist

probes around every tooth in the patient's mouth and then records only the highest score obtained in each sextant.³ (Dr. Campbell testimony)

A complete periodontal examination includes x-rays and a dated full mouth periodontal probing. In a full mouth probing, as opposed to a PSR, the dentist probes every tooth in the mouth and records numbers for every tooth. The standard of care currently requires a full mouth periodontal probing to be performed annually for all patients and at every visit for patients with periodontal issues.⁴ The documented examination should also include assessment and findings concerning attachment loss, bleeding on probing (BOP), and furcation involvement. Finally, the dentist should evaluate and document the patient's oral hygiene practices and any health condition or medications that would affect the patient's periodontal condition. (Dr. Campbell testimony; State Exhibit CC)

If the evaluation establishes that the patient has periodontal disease, the dentist enters a written diagnosis in the patient's chart and develops and documents a treatment plan. The dentist must discuss the treatment plan and treatment options with the patient (or with the patient's guardian) and must communicate to the patient the consequences of treatment vs. non-treatment. The discussions with the patient should be documented in the patient record. If the patient chooses to decline recommended treatment, the patient's refusal to proceed with treatment should be documented in the record. (Dr. Campbell testimony; State Exhibit CC)

Depending on the patient's periodontal condition, appropriate periodontal treatment may include prophylaxis, periodontal scaling and root planing with periodontal maintenance follow-up, and surgery. Prophylaxis is the removal of deposits (calculus) and bacteria above the gum line. Prophylaxis cannot replace periodontal scaling and root planing, which is the removal of bacteria and debris in the periodontal pocket below the gum line using hand instruments. In addition, patients should be evaluated 6-8 weeks after periodontal scaling and root planing and should then be placed on a periodontal

³ Respondent Exhibit 3 at pp. 3-5 provides a detailed description of the PSR screening system. The clinician uses a probe with a .5mm ball at the tip and a color-coded area 3.5mm to 5.5mm from the tip. Using the probe, the clinician takes six measurements for each tooth by inserting the probe into the pocket and walking it around the circumference of each tooth. The clinician reads the probe by observing the position of the color-coded band in relation to the gingival margin. The mouth is divided into sextants, and measurements are recorded in a special box chart. The clinician only records the highest score for each sextant. If the number recorded is a zero, this means that the colored area of the probe remained completely visible in the deepest crevice of the sextant and that no calculus or defective margins were detected. The gingival tissues are healthy with no bleeding after gentle probing.

⁴ See also Respondent Exhibit 3, p. 2 ("The American Academy of Periodontology recommends every dental patient should receive a comprehensive periodontology evaluation annually.")

maintenance schedule with appointments every 3-4 months. (Dr. Campbell testimony; State Exhibits X, Y, BB, CC)

Summary of Dr. Campbell's Written Findings. Dr. Campbell reviewed Respondent's treatment records for MC and for the 18 additional periodontal patients. On April 8, 2015, Dr. Campbell submitted his written report to the Board. Dr. Campbell concluded that Respondent had failed to practice to the standard of care in his diagnosis and treatment of periodontal disease with respect to MC and with respect to 12 other patients who had periodontal disease (KDB, IG, MP, FC, TR, DP, DK, HD, LM, HH, RP, and RD). Dr. Campbell specifically noted that:

- most of the reviewed charts lacked any full mouth periodontal probing depths and that charts that did have probing depths were undated;
- there were periodontal screening records (PSRs) in some of these records, but many of the PSRs had recorded findings of all zeros. The zero scores could not have been correct given Dr. Campbell's review of the patients' x-rays;
- when Respondent documented that he performed scaling and root planing, he immediately returned the patients to 6 month recall visits and did not put any of the patients on a 3-4 month periodontal maintenance schedule;
- the patient records did not include any documentation to show that Respondent had recommended more frequent follow-up visits or that he had explained the potential consequences of failing to come in for more frequent visits.

(Dr. Campbell testimony; State Exhibit Y)

Dr. Campbell did not make any findings of substandard care with respect to the remaining 6 patients whose records he reviewed. While 5 of those patients did not have any periodontal probing depths recorded, there was also no evidence that these patients had periodontal disease. The sixth patient had been treatment planned by Respondent for extractions and full upper and lower dentures. Dr. Campbell agreed with Respondent's treatment plan for this patient. (Dr. Campbell testimony; State Exhibit Y)

Respondent's Written Response. On April 21, 2015, Brian Sedars sent a letter to Respondent in which he summarized the treatment issues and concerns that had been identified in the course of the investigation and invited Respondent to provide a written response. Sedars did not identify Dr. Campbell or his role as a board consultant, and he did not provide Respondent with a copy of Dr. Campbell's written report, which was a

confidential document at that time.⁵ Respondent was not given a copy of Dr. Campbell's written report until after the Statement of Charges was filed. (Sedars, Argo testimony; State Exhibit Z)

On May 22, 2015, Respondent sent a 20 page letter to Brian Sedars, in response to the concerns outlined in the April 21, 2015 letter. Respondent's testimony at hearing included similar statements about his care of periodontal patients in general and these patients in particular. In his letter, Respondent stated, in part:

- that the prior evaluation of his dental skills at the University of Illinois-Chicago determined that he did not need any clinical training because his diagnostic skills, treatment planning, and clinical ability ranked in the top 3% of dentists nationwide;
- that since he had already paid the University for two days of training, it was decided that he should instead receive training on SOAP note charting, and he was taught to use PSR and PFS (plaque free score) to monitor periodontal health of patients;
- that a patient is considered to have periodontal disease when a 3 is recorded in any sextant of the PSR, and a patient with less than 3 does not have periodontal disease;
- that 40% of his patients have limited financial resources whose dental benefits rely solely on Medicaid, a majority of those patients live in care facilities, Medicaid pays a small fraction of his fee and frequently refuses to cover the services provided, and he often provides care free of charge;
- that except for MC, all of the other patients reviewed were Medicaid patients, with the majority living in care facilities;
- that Medicaid patients are often times more difficult to work with due to physical or mental disabilities, poor home oral care, and limited funds that make it more difficult to develop or carry out a treatment plan;
- that there have been many years during his care of patients when Medicaid did not cover periodontal services and currently permission can be obtained for some periodontal services but there are procedures that must be strictly followed;
- that it is a hardship for Medicaid patients to wait for Medicaid approval and to have to return for another visit to receive treatment;

⁵ See *Doe v. Iowa State Bd. of Physical Therapy*, 320 N.W.2d 557, 559-561 (Iowa 1982) (holding that Iowa Code section 258A.6(4) [now 272C.6(4)] requires disclosure of investigative information in the possession of a licensing board to the licensee only after the initiation of charges. Prior to the initiation of charges, investigative information is confidential and is not subject to disclosure to the licensee.)

- that depending on patient's medical health, anxiety level, and other conditions, he may scale the teeth (PSRP) and perform a prophylaxis, both of which are recorded in the chart, but then only charge for the prophylaxis;
- that he has not been able to qualify even one of his patients for 3-month periodontal maintenance through Medicaid and that he has been told that patients must have had periodontal surgery to qualify for 3-month maintenance visits;
- that most of his periodontal patients are scheduled for re-care in approximately six months. In the majority of cases, the return visit involves either sonic or ultrasonic scaling; and
- that he has had good results with this approach to periodontal care. (State Exhibit AA)

Respondent's 20 page written response was provided to Dr. Campbell for his review. On July 6, 2015, Dr. Campbell issued a follow up report, which reiterated his opinion that Respondent is not practicing to the standard of care in the area of periodontics. It was Dr. Campbell's opinion that many of Respondent's responses to the concerns that were raised indicate that Respondent lacks the diagnostic or clinical ability to appropriately treat periodontal disease. (State Exhibit BB; Testimony of Dr. Campbell)

Findings for Individual Patients

MC. MC had dental appointments with Respondent approximately every six months over a fourteen year period from his initial appointment in July 1999 until his last appointment on June 3, 2013. After reviewing Respondent's records as well as the records provided by Dr. Gleichman and Dr. Statz, Dr. Campbell concluded that the periodontal treatment that Respondent provided to MC failed to conform to the current standard of care. (Dr. Campbell testimony; State Exhibits F-J, AA, CC) The Board agrees with Dr. Campbell.

Respondent states that MC came into his practice with gingivitis, very heavy calculus, and bone loss. Respondent maintains that over the 14 years that he provided MC's dental treatment, MC had no significant additional bone loss and his gingivitis had not progressed to periodontitis. (State Exhibit AA; Respondent testimony)

Respondent claims that he recommended that MC come in more frequently than every 6 months but that MC refused more frequent appointments because they would not be covered by his dental insurance. MC could recall only one occasion when Respondent told him that it might be better for both of them if MC came in more often than twice a year. MC could not recall exactly when Respondent made this suggestion but believed it

may have been midway through the 14 years of treatment he received from Respondent. MC admits that he decided not to come in more frequently after he learned that his dental insurance would not cover more frequent visits. There is no documentation in the record that MC's insurer denied approval for more frequent visits. MC admitted that he had rejected Respondent's suggestion that he use an electric toothbrush. (Respondent, MC testimony; State Exhibits E, AA)

MC, who was a credible witness, testified that Respondent never explained to him what might happen to his dental condition if he did not have more frequent dental appointments. Respondent never told MC that he had periodontal disease or bone loss, and MC could not recall Respondent ever discussing gingivitis with him. Respondent always told MC that everything "looked very good" and that he should continue what he was doing. Respondent's patient records include repeated documentation of Respondent's assessment that MC's teeth and gums look "healthy" and that MC is "doing a great job." (MC testimony; State Exhibits E, F)

Dr. Campbell observed subgingival calculus and bone loss on MC's bitewing x-rays starting in 2007. In reviewing the yearly x-rays for MC from 2007-2013, Dr. Campbell observed increasing accumulation of subgingival calculus and bone loss. By 2010, MC had generalized bone loss throughout his mouth. Dr. Campbell described MC's bone loss as "pretty significant" by 2012. In addition, the chronological x-rays show the same calculus in the same areas year after year, which Dr. Campbell concluded was the result of Respondent not removing the calculus during treatment. (Dr. Campbell testimony; State Exhibit Y)

There were no entries in Respondent's record that diagnosed MC's deteriorating periodontal condition or his periodontal disease. There was also no documented periodontal treatment plan for MC. Respondent's periodontal screening records (PSR) for MC were routinely all zeros. In Dr. Campbell's opinion, there was no way that MC's periodontal screening records could have been all zeros if Respondent had performed the screenings correctly. There were also no full mouth periodontal probings documented in MC's chart. Rather, Respondent's entries in MC's chart indicated that MC's overall oral condition was good. (Dr. Campbell testimony; State Exhibit Y)

Respondent testified that he uses the PSR to show if there is bleeding on probing and that the only PSR score that does not include bleeding on probing is a zero. Respondent will perform a full mouth periodontal probing only when a patient's PSR numbers are 3s or 4s. Respondent stated that MC's PSR from his last appointment on June 3, 2013 recorded all zeros because there was no bleeding on probing at that time. Respondent conceded

that Dr. Gleichman's findings on August 14, 2013 were significantly different than his findings two months earlier. (Respondent testimony)

Respondent testified that he performed periodontal scaling and root planing on MC at his very first dental appointment on July 29, 1999. MC does not recall Respondent ever discussing scaling and root planing with him as a possible treatment plan. Respondent's documentation for MC's first visit states, in relevant part: "Initial exam, sonic scale, AP Prophy..." and then states: "NV: 6 mos/periodontal scaling." NV refers to "next visit." At MC's next visit on January 31, 2000, Respondent's documentation indicates that he provided a periodic exam, ultrasonic scale, AP Prophy." Respondent testified that he performed all four quadrants of periodontal scaling at this single visit and that he used a sonic scaler to perform the periodontal scaling. When asked if this included "root planing," Respondent hesitated but then answered yes. (Respondent, MC testimony; Respondent Exhibit A; State Exhibit F)

Respondent stated that MC (and some of his other patients) received some "expensive periodontal services" periodically at the cost of a routine prophylaxis. According to Respondent, these services included sonic scaling/ultrasonic scaling along with air polishing prophylaxis. Respondent characterizes these services as the "equivalent" of periodontal scaling and root planing. Respondent testified that the appointments, which included x-rays if needed, an examination, and his periodontal services lasted approximately 45 minutes to one hour. Respondent did not use local anesthesia when performing periodontal scaling on any of the 13 patients at issue in this proceeding. Respondent testified that he is a very gentle dentist and that most of his patients don't need anesthesia when he performs periodontal scaling. When asked how he was trained to perform periodontal scaling and planing when he was in dental school, Respondent admitted that he was taught to always use hand instruments and that local anesthesia was typically required. Nevertheless, Respondent no longer uses any hand instruments when he performs periodontal scaling. Respondent contends that the ultrasonic scaler is just as effective as scaling and root planing using hand instruments. When Respondent uses the sonic scaler or ultrasonic scaler, his staff would typically only bill for a regular prophylaxis. (Respondent testimony; State Exhibit AA)

Respondent described the difference between the sonic and ultrasonic scalers as being the frequency at which they vibrate. When asked if there is any difference between his references to "periodontal scaling" and to "sonic scaling" in his notes, Respondent stated that if he writes "sonic scale" it means that he is doing a thorough cleaning of the plaque and calculus, both above and below the gum line. If he uses the term "periodontal scaling" it is the same process but "much more intensive and time consuming." If he does not use the

word “scale” in his documentation, then it means that he is only polishing the teeth. (Respondent testimony; State Exhibit F)

Respondent maintained that he properly cleaned MC’s teeth and removed all calculus but that MC quickly forms a hard to remove type of subgingival and superingival calculus. Respondent maintains that there would have been more bone loss if his periodontal treatment of MC was not working. (Respondent testimony; State Exhibit F)

With respect to MC, Dr. Campbell disagreed with Respondent’s characterization of MC’s bone loss as “minimal” over the 14 years of his treatment and stated his opinion, based on 14 years of x-rays, that MC’s bone loss was substantial. Dr. Campbell could not find any documentation in MC’s record that Respondent ever documented a diagnosis of periodontal disease or that he discussed treatment options with MC, including a discussion of expected outcomes with and without recommended treatment. Dr. Campbell continued to question how all of MC’s PSRs could have been zeros, when his x-rays show bone loss with subgingival calculus, and how MC could have the same amount of calculus in the same area year after year if Respondent was properly removing the calculus at each appointment. Finally, Dr. Campbell noted that Respondent’s last entry indicated that MC did not have periodontal disease when he left his practice in 2013. Dr. Campbell responded that he could “state with certainty” that MC’s periodontal disease did not just occur in the six months between his last visit to Respondent and his first visit to Dr. Gleichman.⁶ (Dr. Campbell testimony; State Exhibit BB)

Since leaving Respondent’s dental practice, MC has received treatment from both Dr. Gleichman and Dr. Statz. In December 2015, the Board subpoenaed additional treatment records from Dr. Gleichman and Dr. Statz. The records confirm that MC received scaling and root planing on all four quadrants in Dr. Statz’s office during appointments on September 13, 2013 (upper right and lower right quadrant) and September 20, 2013 (upper left and lower left) and that MC’s insurance covered these services. MC testified that the scaling and root planing was performed by Dr. Statz’s dental hygienist. MC had periodontal follow-up appointments with Dr. Statz in January 2014 and in May and November 2014. (MC testimony; State Exhibit J)

Dr. Gleichman prepared and placed a crown for MC on tooth #31 in October 2013. In February 2014, Dr. Gleichman prepared and placed a crown on tooth #18. Dr. Gleichman

⁶ Dr. Campbell also made additional statements based on his erroneous assumption that MC lost teeth after he left Respondent’s dental practice. The evidence at hearing established that MC has not in fact lost any teeth since he left Respondent’s practice, and this fact was taken into account by the Board in making its findings. (State Exhibit AA; Campbell, MC testimony)

saw MC for routine exams and x-rays on August 18, 2014. On February 10, 2015 and August 11, 2015, Dr. Gleichman's office completed "[a]dult prophylaxis, scale, and periodontal charting" and documented that MC had light plaque and moderate calculus. (State Exhibit I, MC testimony)

Dr. Campbell testified at hearing concerning his review of MC's patient records, including the more recent dental records that were obtained from Dr. Gleichman and Dr. Statz after Dr. Campbell's initial report. Much of his testimony reiterated the prior findings in his reports to the Board. He conceded that his conclusion that MC lost teeth was inaccurate, in light of the more recent dental records but this did not change his opinions concerning Respondent's treatment of MC. Dr. Campbell testified that in his professional opinion, Respondent's failure to properly diagnose and treat MC's periodontal disease was a failure to conform to the standard of care and a failure to maintain a satisfactory standard of competency with respect to the diagnosis and treatment of periodontal disease. Dr. Campbell further concluded that Respondent's failure to document MC's increasing bone loss, his changing periodontal condition, and any discussions concerning MC's periodontal condition and his treatment options constituted a failure to maintain patient records in a manner consistent with the protection of the welfare of the patient. (Dr. Campbell testimony; State Exhibits Y, BB)

KDB. Respondent's records for this patient cover a period of 13 years, starting in 2001. KDB's chart had an undated record of a full mouth periodontal probing, with recorded pockets that were mainly 5, 6, and 7mm. There was bone loss present on x-rays from 2001, and the patient's bitewing x-rays showed bone loss and an increase in subgingival calculus. Respondent had no diagnosis of periodontal disease in his treatment record for this patient even though the x-rays and probing depths should have alerted a prudent practitioner that KDB had periodontal disease. (Dr. Campbell testimony; State Exhibits L, Y)

Respondent stated that KDB came to him from Broadlawns Dental Clinic with advanced periodontitis and a treatment plan to extract all of her teeth. Respondent maintains that referral to a periodontist was not an option and that there were years during KDB's treatment when Medicaid did not provide periodontal coverage. Respondent monitored KDB with PSR, BOP, and PFS and continued to scale her teeth at recare visits for free. According to Respondent, KDB has been able to keep many of her own teeth, her home care is improving, and her gums are in better shape. (State Exhibit AA; Respondent testimony)

IG. Dr. Campbell reviewed dental records for IG from her initial appointment with Respondent on December 27, 2012 through April 23, 2014, which was a total of four

appointments. IG was an elderly Medicaid patient who resided in a care facility. Respondent performed a full mouth probing on this patient. Although the patient had generalized 5 mm pockets and there was evident bone loss on x-rays, Respondent did not document a diagnosis of periodontal disease in the patient record. On January 8, 2013, Respondent requested prior authorization from Medicaid for four quadrants of periodontal scaling and root planing, and Medicaid approved the request 10 days later. Respondent performed the four quadrants of periodontal scaling and root planing on January 10, 2013, but he did not place the patient on a periodontal maintenance schedule. Respondent next saw IG on September 18, 2013, more than 8 months after the periodontal scaling and root planing. The x-rays taken at IG's next visit on April 23, 2014 showed continuing deterioration of IG's periodontal condition, but there is no documentation in the chart that Respondent recognized this. (Dr. Campbell, Respondent testimony; State Exhibits M, Y)

Respondent maintains that IG did not meet Medicaid's requirements for periodontal maintenance therapy. Respondent's records do not include any documentation that he requested approval from Medicaid to place IG on a periodontal maintenance plan. Respondent submitted some limited documentation from the Department of Human Services concerning coverage and limitations for dental services in general. This documentation indicates that as of July 1, 2002:

- Medicaid was approving payment for periodontal scaling and root planing when (1) the request for approval was accompanied by a periodontal treatment plan, a completed copy of a periodontic probe chart that exhibited pocket depths, a periodontal history, and radiographs; and (2) interproximal and subgingival calculus is evident in the x-rays or the dentist justifies and documents that curettage, scaling, or root planing is required in addition to routine prophylaxis;
- Medicaid was approving payment for periodontal maintenance therapy every three months for moderate to advanced cases if the condition would deteriorate without further treatment.

(Respondent testimony; State Exhibit M; Respondent Exhibits 5-7)

MP. The record includes Respondent's treatment records for MP from April 1, 2008 through August 12, 2014. Respondent reported that this patient was a heavy smoker who had 5-8 mm bone loss throughout his mouth and severe gum recession. Respondent reports that he told MP that smoking was a major factor in his missing teeth, but the patient refused to quit smoking or seek the care of a periodontist. There is no documentation of this discussion in the patient's chart. According to Respondent, MP was mainly interested in emergency care and only came in when he had a toothache.

Respondent reports that his treatment plan was aggressive cleaning treatment (periodontal services) when he comes in, x-rays, restorations as needed, and extractions if necessary. Respondent continued to monitor MP's BOP (bleeding on probing) and by 2010, the patient only required routine prophylaxis without scaling. (Respondent testimony; State Exhibits N, AA)

Dr. Campbell noted that there was bone loss evident on MP's initial x-rays, but Respondent never performed a full mouth periodontal probing. Subsequent yearly x-rays showed increasing bone loss, but Respondent had no diagnosis of periodontal disease or increasing bone loss in his treatment record for this patient. (Dr. Campbell testimony; State Exhibits N, Y)

FC. FC, who has Down's Syndrome, was first seen by Respondent on August 3, 2003 and was accompanied to each appointment by his caretaker and guardian. Patients with Down's Syndrome are prone to periodontal disease and this patient had severe bone loss, very mobile teeth, several decayed and abscessed teeth, and poor oral hygiene. Standard treatment would have been to extract all teeth and make complete dentures, but this was not done because complete dentures can be difficult for patients with Down's Syndrome. Respondent stated that his treatment plan was to treat decay so FC would not be in pain, to extract his teeth as they became too loose to save, and to provide scaling, prophylaxis, and fluoride treatments to slow down bone loss and decay and to put off dentures for as long as possible. (Respondent testimony; State Exhibit AA)

Dr. Campbell reviewed Respondent's records for FC from August 2003 through September 2014. Dr. Campbell noted that there was bone loss evident on the patient's initial x-rays, but there is no documentation that Respondent ever performed a full mouth periodontal probing or that he diagnosed periodontal disease. (Dr. Campbell testimony; State Exhibits O, Y)

RD. RD resides in a care facility and receives Medicaid benefits. Respondent testified that RD has multiple medical and mental conditions, and he is a heavy smoker with "rampant decay." RD has severe gingivitis and bone loss due to poor oral home care and tobacco induced periodontal disease. Respondent testified that RD's chart shows that Respondent provided him with periodontal care. (Respondent testimony; State Exhibits P, AA)

Dr. Campbell observed that although there is bone loss evident on the x-rays taken in 2000, there is no diagnosis or periodontal depths documented in RD's record. Respondent continued to see this patient every 6 months, and the patient's condition

continued to deteriorate without Respondent ever diagnosing periodontal disease. (Dr. Campbell testimony; State Exhibits P, Y)

TR, DP, DK, HD, LM, HH, RP. Dr. Campbell observed that although Respondent documented that he performed scaling and root planing on these patients, he did not place any of these patients on a periodontal maintenance schedule. The patients were only asked to return for routine 6 month visits. (Dr. Campbell testimony; State Exhibits Q-W, Y)

Respondent stated that all of these patients resided in care facilities and received Medicaid. Respondent maintains that the treatment plans for these patients included any necessary periodontal services (often done for free) when Respondent returned to their care facility. Respondent stated that the patients did not meet Medicaid's requirements for periodontal maintenance therapy. Respondent did not provide any documentation that he requested Medicaid approval for periodontal maintenance therapy for these patients. (Respondent testimony; State Exhibits Q-W, AA)

In summary, Dr. Campbell identified similar deficiencies in the treatment that Respondent provided to MC and to the 12 other periodontal patients. Dr. Campbell found that Respondent's treatment of these patients fell below the standard of care because he:

- failed to perform and document full mouth probing;
- failed to properly diagnose and to document the diagnosis of the patient's periodontal disease;
- failed to document a periodontal treatment plan;
- failed to place any of the patients on a periodontal maintenance schedule even after scaling and root planing was reportedly performed; and
- failed to document his discussion of the diagnosis and recommended periodontal treatment with the patient, including the expected outcomes with and without treatment.

Dr. Campbell has treated Medicaid patients who have periodontal issues. It has been his experience that Medicaid will pay for periodontal treatment and for periodontal maintenance if the dentist provides a proper diagnosis and appropriate records to support the diagnosis and treatment plan. Medicaid does not require patients to have had periodontal surgery prior to granting approval for periodontal treatment and maintenance. (Campbell testimony; State Exhibits L-Y, BB)

CONCLUSIONS OF LAW

Count I - Failure to Maintain a Satisfactory Standard of Competency

Iowa Code section 153.34(8) and 650 Iowa Administrative Code (IAC) 30.4(16) authorize the Board to discipline a licensee for failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry, dental hygiene, or dental assisting.

The preponderance of the evidence established that Respondent failed to maintain the appropriate standard of care in his diagnosis, treatment planning, treatment, and recordkeeping for patients with periodontal disease. After reviewing the entire record, including but not limited to the patients' records and x-rays, the Board agrees with the opinions expressed by Dr. Campbell concerning Respondent's repeated failure to conform to the standard of care in his treatment of patients with periodontal disease. Respondent has repeatedly failed to properly evaluate the patients' periodontal condition, has repeatedly failed to identify and document the diagnosis of periodontal disease, and has failed to provide appropriate treatment and follow up maintenance treatment for patients with periodontal disease.

Respondent's treatment records and his own testimony established that he is not appropriately using or documenting the periodontal screening record (PSR). Respondent's records include a number of PSR charts that are not actually PSRs but are meant to be charting of bleeding on probing (BOP). A subsequent dentist would not have been able to determine what these screenings meant for purposes of providing continuing care.

In addition, Respondent repeatedly failed to perform and document full mouth probings when such an examination was clearly required, and he failed to diagnose and document increasing bone loss in several patients. Respondent's records did not include a written diagnosis of periodontal disease and did not document a periodontal treatment plan. There was no documentation that Respondent discussed the diagnoses and treatment plans with the patients or that he explained the potential consequences of foregoing recommended treatment. There was no documentation that the patients refused treatment following such a discussion or that insurance refused to pay for treatment after documentation to support the requested treatment was submitted by Respondent.

Respondent's records and testimony raise serious concerns about the appropriateness and efficacy of the periodontal services that he has provided to these patients. Use of a sonic scaler and ultrasonic scaler is not an adequate substitute for scaling and root planing using hand instruments. It is extremely unlikely that Respondent could have

provided thorough and effective scaling and root planing to all of these patients without using any hand instruments to perform scaling and without any anesthesia. It is also extremely unlikely that effective scaling and root planing could be provided as part of a routine appointment lasting just 45 minutes to 1 hour in length. It is certainly clear from MC's x-rays that Respondent's use of a sonic scaler and ultrasonic scaler did not effectively remove all calculus and that MC's periodontal condition continued to deteriorate.

Count II – Failure to Maintain Patient Records in a Manner Consistent With the Protection of Patient Welfare

650 IAC 27.11 requires dentists to maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

650 IAC 27.11(1)"d" pertains to clinical examination progress notes and specifies, in relevant part, that dental records shall include chronological dates and descriptions of the following: (1) clinical examination findings, tests conducted, and a summary of all pertinent diagnoses; (2) plans of intended treatment and treatment sequence; (3) services rendered and any treatment complications; (4) all radiographs, study models, and periodontal charting, if applicable;...

650 IAC 27.11(1)"e" pertains to informed consent and requires dental records to include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and patient's consent to proceed with treatment.

The preponderance of the evidence established that Respondent failed to comply with the standard of care for record keeping, as required by 650 IAC 27.11, when he failed to properly document his assessments, diagnoses, and treatment plans for periodontal patients. Respondent also failed to document his discussions with the patient (including potential complications and known risks) concerning the recommended treatment and failed to document the patient's refusal of recommended treatment.

Count III - Failure to Comply With Board Decision Imposing Discipline

Iowa Code section 272C.3(2)(a)(2015) and 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. It is undisputed that Respondent has not complied with any of the requirements of the Board's July 2, 2013 Decision and Order. Respondent has not

retained a Board approved outside Infection Control Trainer and has not provided written verification of annual training for himself and his staff. Respondent has not entered into an approved written agreement with a Board approved Practice Monitor for infection control, has not had random visits to his dental office from a Board approved Practice Monitor, and has not submitted any quarterly reports from a Practice Monitor. Respondent has not submitted any quarterly written reports. Respondent has not paid the \$5,000 civil penalty and he has not paid the \$75.00 hearing fee.

Respondent has not provided any reasonable basis for his failure to comply with a final order of the Board. The July 2, 2013 Decision and Order was issued following an evidentiary hearing based on the evidence in the record. The Decision and Order was affirmed on judicial review, and Respondent withdrew his appeal to the Supreme Court. No Stay Order was ever issued, and Respondent never filed any written request or petition asking the Board to modify the terms of probation. Respondent's contention that one of the witnesses in his disciplinary hearing was lying does not excuse or justify his complete failure to comply with the requirements of the Board's Decision and Order. Respondent has violated Iowa Code section 272C.3(2)(a)(2015) and 650 IAC 30.4(23).

DECISION AND ORDER

IT IS THEREFORE ORDERED that Iowa dental license 6782, issued to Respondent Jay Buckley, D.D.S, is hereby INDEFINITELY SUSPENDED. The license suspension shall continue until the Board has received satisfactory evidence of Respondent's full compliance with the terms of the July 2, 2013 Decision and Order. In order for the license suspension to be vacated, Respondent must:

- Submit the name of a qualified Infection Control Trainer for Board approval;
- Submit the name of a qualified Infection Control Monitor and a written monitoring agreement for Board approval;
- File Respondent's first written quarterly report to the Board; and
- Pay the \$5,000 civil penalty and the \$75.00 hearing fee in full.

IT IS FURTHER ORDERED that the license suspension is hereby STAYED for a limited period of thirty (30) days. This 30 day stay of suspension will allow Respondent a final opportunity to fully comply with the Board's July 2, 2013 Decision and Order without losing his privilege to practice dentistry. Alternatively, the 30 day stay will allow Respondent an opportunity to refer his current patients to other dentists if he is unable or unwilling to fully comply with the Board's July 2, 2013 Decision and Order.

IT IS FURTHER ORDERED that if and when Respondent's license suspension is vacated by the Board, his Iowa dental license will automatically be placed on INDEFINITE PROBATION, subject to the following terms and conditions:

A. Respondent shall be prohibited from performing periodontal procedures, including but not limited to root planing and scaling. The prohibition against performing periodontal procedures will continue until Respondent has completed a Board-approved remedial education program in the area of periodontics. The education program must include a clinical component, which may be completed either through a dental school or through a dental hygiene school. Respondent shall be responsible for all costs of the remedial education program.

B. Respondent shall obtain a Board-approved Practice Monitor for periodontal diagnosis, treatment planning, treatment, and recordkeeping. The practice monitor shall be an Iowa licensed dentist approved by the Board. Within sixty (60) days of the date of this Order, Respondent shall submit a written practice monitoring plan for Board approval. The plan shall include the following:

1. On a monthly basis, the practice monitor shall randomly select a designated number of Respondent's patient records and shall conduct a review of those records to ensure that they conform to the appropriate standard of care for periodontal diagnosis, treatment planning, treatment, and recordkeeping. After one (1) year, the Board may, at its discretion, order that these reviews be conducted on a quarterly basis or semi-annual basis.
2. Respondent shall ensure that the practice monitor submits a monthly written report to the Board following each records review for the first six (6) months. Thereafter, the practice monitor's written reports may be submitted quarterly. The practice monitor shall immediately report to the Board any discrepancies in record keeping, or any competency concerns. The practice monitor shall make any necessary recommendations for changes in Respondent's record keeping and/or clinical practice.
3. Respondent shall fully comply with all recommendations made by his practice monitor.
4. Respondent shall be solely responsible for the costs associated with practice monitoring. Respondent shall promptly reimburse the practice monitor the usual and customary fee for the services.

C. Respondent shall submit quarterly written reports on the form provided by the Board no later than the first day of January, April, July, and October of each calendar year. The reports shall detail Respondent's compliance with all of the terms of this Order.

D. Respondent shall upon reasonable notice and subject to the provisions of 650 IAC 31.6 appear before the Board at the time and place designated by the Board.

E. Any violation of the terms of this Decision and Order will result in additional and more severe discipline, up to and including license revocation.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 650 IAC 51.35 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 16th day of June, 2016.

Handwritten signature of Steven P. Bradley, D.D.S. in cursive script, with the initials "D.D.S." written to the right of the signature.

Steven Bradley, D.D.S.
Chairperson
Iowa Dental Board

cc: Sara Scott, Assistant Attorney General, Hoover Building (LOCAL)
Steven P. Wandro, Wandro & Associates, P.C., 2501 Grand Avenue, Suite B, Des Moines, Iowa 50312 (CERTIFIED)

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).