BEFORE THE WEST VIRGINIA BOARD OF DENTAL EXAMINERS

WEST VIRGINIA BOARD OF DENTAL EXAMINERS,

Complainant,

v. **Case No. 2007-DB-0010D**

DR. JAMES G. BRYANT,

Respondent.

FINAL ORDER

This matter came on for hearing on April 11, 2008, August 28, 2008 and August 29, 2008, before Hearing Examiner Jack McClung, Esquire, all pursuant to West Virginia Code §§ 30-4-1 *et seq.*, 30-4A-1 *et seq.* and West Virginia Code R. 5-5-4 *et seq.* The West Virginia Board of Dental Examiners (Board) was represented by Darlene Ratliff-Thomas, Assistant Attorney General and Dr. James G. Bryant (Respondent) was represented By Edward C. Martin, Esquire.

After due consideration of the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Examiner along with the record and exhibits admitted into evidence in this matter, the Board[1] reviewed and discussed each individual violation as well as the severity of each violation. The Board unanimously voted to accept

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[1] Dr. H. Richard Marshal, Jr. served on the Complaint Committee in this matter, therefore, he was excused from the room during the deliberations. He did not participate in the deliberation nor did he cast a vote.

the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Examiner in its entirety.

Wherefore, based upon the above, the Board in its sworn duty to protect the public and the integrity of the profession, ORDERS as follows:

1. The Board shall adopt and ratify the Findings of Facts, Conclusions of Law and Recommended Order of the Hearing Examiner in its entirety, incorporated by reference herein.

2. That the license issued to the Respondent, James G. Bryant, to practice dentistry in the State of West Virginia is hereby REVOKED.

3. The Respondent shall reimburse the board for all its cost associated with the prosecution of this matter in the amount of Eighteen Thousand Two Hundred One and 05/100 Dollars ($18, 201.05).

Pursuant to West Virginia Code § 29A-5-4(b) an appeal of this decision may be made to the Circuit Court of Kanawha County or in the circuit court of the county in which the licensee resides or does business. This appeal must be filed within 30 days after receiving notice of this decision.

ENTERED into the records of the Board this 1st day of April 2009.

WEST VIRGINIA BOARD OF
DENTAL EXAMINERS

David G. Edwards. DDS
Board President

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DR. JAMES G. BRYANT,

Respondent.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

This matter comes before the undersigned Hearing Examiner Jack C. McClung by the contest of Respondent James G. Bryant (hereinafter "Bryant") of a Statement of Charges and Notice of Hearing, dated December 13, 2007, issued against the said Respondent by the Complainant West Virginia Board of Dental Examiners (hereinafter "Board").

This matter came on for evidentiary hearing on April 11, 2008, and was thereafter continued to August 28 and 29, 2008. The Complainant Board appeared by Assistant Attorney General Darlene Ratliff-Thomas and representative Dr. H. Richard Marshall, Jr. The Respondent appeared in person and by counsel Edward Martin.

During the evidentiary hearing, the Board called as its witnesses the following: expert witness Daniel Becker, DDS; Board Administrative Secretary, Susan M. Combs; Board Member Richard Marshall, DDS; Board Anesthesia Committee Members, Lewis Gilbert, DDS; and Timothy Thorne, DDS; and introduced eighteen (18) exhibits, all of which were made a part of the record.

Respondent testified on his own behalf and called as his witnesses the following: expert witness Jeffrey Dembo, DDS; Robert Graves, DDS; William Marshall, DDS; and Bryan Weaver, MD, DDS. Respondent introduced eight (8) exhibits, all of which were made part of the record. (Vol. I-III. Trans.). The Board recalled Dr. Gilbert in rebuttal.

All witnesses were sworn, documents were received into evidence, the hearing was recorded electronically, and a transcript prepared and distributed to the parties. After a review of the record and exhibits admitted into evidence at the hearing of this matter, after assessing the credibility of all testimony of witnesses of record and weighing the evidence in consideration of the findings as to credibility, and after consideration of the proposed findings of fact and conclusions of law as were filed by the parties, the undersigned hearing examiner makes the following findings of fact, conclusions of law, and proposed order. To the extent that these findings and conclusions are inconsistent with any proposed findings of fact and conclusions of law submitted by the parties, the same are rejected by the hearing examiner. Conversely, to the extent that these findings and conclusions are generally consistent with any proposed findings of fact and conclusions of law submitted by the parties, the same are accepted and adopted. To the extent that the testimony of any witness is not in accordance with these Findings and Conclusions, such testimony is not credited. Any proposed finding of fact, conclusion of law, or argument proposed or submitted by a party but omitted herein is deemed irrelevant or unnecessary to the determination of the material issues in this matter.

CREDIBILITY OF WITNESSES, TESTIMONY, AND EXHIBITS

The hearing examiner was and is satisfied that all records and documents entered as exhibits are complete, authentic and valid, and that they were entered with the proper evidentiary foundations.

The hearing examiner was and is satisfied that the witnesses brought on by the parties were credible and truthful except as noted below. Neither the demeanor of the witnesses nor the substance of any testimony suggested any inconsistency, conflict, or ulterior motive except as noted below.

FINDINGS OF FACT

1. On June 11, 1997, the Complainant Board issued a license to Respondent Bryant to practice dentistry in the State of West Virginia.

2. The Complainant Board is a regulatory agency created for the purpose of regulating the practice of dentistry in the State of West Virginia. W. Va. Code § 30-4-1 et seq. (the "Dental Practice Act").

3. Respondent Bryant is properly subject to the jurisdiction of the Board as to the subject matter.

4. At the time of the filing of the Complaint in this matter, Respondent Bryant held a Class 3(b) anesthesia permit which allowed him to induce conscious sedation through the administration of nitrous oxide and oxygen and/or the administration of other agents either enteral or parenteral.

5. As a result of a prior consent decree between the Complainant and the Respondent entered on December 9, 2005, the West Virginia Board of Dental Examiners, Anesthesia Committee (hereinafter "Anesthesia Committee") was to conduct unannounced site visits to the offices of the

Respondent to review Respondent's compliance with W. Va. Code § 30-4A-1 et seq., specifically as it relates to his Class 3b anesthesia permit.

6. From January 2006 through July 2006, the Anesthesia Committee conducted a total of nine unannounced site visits to Respondent Bryant's Morgantown and Fairmont offices.

7. Following the site visits, the Anesthesia Committee prepared certain reports and evaluations which were submitted to Dr. H. Richard Marshall, Jr. Dr. Marshall is a member of the West Virginia Board of Dental Examiners and serves as the non-voting chairman of the Anesthesia Committee and as the liaison between the Board and the Anesthesia Committee.

8. Upon receiving the Anesthesia Committee reports regarding the Respondent, Dr. Marshall recommended that the Board appoint a Complaint Committee to review the matter and determine if the Respondent had violated any provision of pertinent statute or regulation. The Board did thereafter appoint a Complaint Committee and appointed Dr. Marshall and Dr. Bernard Grubler to serve on the committee.

9. The Complaint Committee did then conduct an investigation into the practice of the Respondent which included the reports of the Anesthesia Committee as well as a review of the Respondent's controlled substance prescription writing practices.

10. At the conclusion of its investigation, the Complaint Committee made a recommendation to the Board that there was probable cause to believe that the Respondent Bryant had violated the Dental Practice Act.

11. The Board thereafter issued on December 13, 2007, a Statement of Charges and Notice of Hearing in this matter. (Bd. Ex. 8.)

12. The said Statement Of Charges alleged, in pertinent part:

a. That the Respondent knowingly utilized Ann Jacobs, a dental assistant, as an anesthesia monitor at a time when Ms. Jacobs had not fulfilled the requirements of the Board as a monitor and could not provide proof of a Basic Life Support (BLS/CPR) Certification upon request of the Board (Paragraph 7(a)-(c) of the Statement Of Charges);

b. That during procedures in which nitrous oxide was used the Respondent knowingly used dental assistants who had not taken the Board-required nitrous oxide monitoring course and had not received a certificate for such procedures from the Board (Paragraph 7(d) of the Statement of Charges);

c. That on April 20, 2006, an unannounced inspection of Respondent's Fairmont office by members of the Anesthesia Committee discovered that the manufacturer's expiration date on a vial of the drug "Narcan" had been altered by the said expiration date having been written over in longhand thereby voiding the pedigree of the medication (Paragraph 8 of the Statement Of Charges);

d. That during a February 28, 2006, unannounced site inspection/visit to Respondent's Fairmont office by members of the Anesthesia Committee, it was observed that Respondent administrated Versed and Fentanyl in dosages that were construed to be excessive for a 30 to 40 minute procedure, especially without documented incremental dosing. This was specifically evident in the cases of two patients: BS and DS (Paragraphs 9 and 10 of the Statement Of Charges);

e. That the Respondent prescribed controlled substances and sedatives for chronic pain in a neglectful manner and not within conventional guidelines for chronic pain

management in that he habitually prescribed controlled substances to multiple members of a single family without rendering treatment (Paragraphs 11 and 12 of the Complaint); and,

f. That a review of various patient records by members of the Anesthesia Committee demonstrated incidences of inadequate record-keeping that reflected breaches in the standard of care with regard to proper patient management in that, specifically, (i) Respondent failed to record oxygen saturations of the patient on the anesthesia Record; and (ii) Respondent was negligent in recording the start time of administering anesthesia and the patient's vital signs (Paragraph 13 of the Statement of Charges).

13. As to the issue of the use of an unqualified anesthesia monitor, this allegation is based on the observations made during a March 3, 2006, site visit to Respondent's Morgantown office by Lewis Gilbert, DDS, a member of the Anesthesia Committee of the Board. From the evidence adduced at hearing, it is found that Ms. Jacobs was, in fact, acting on March 3, 2006, as an anesthesia monitor and that she had not fulfilled the requirements of the Board as a monitor and could not provide proof of a Basic Life Support (BLS/CPR) Certification. Although Respondent's expert witness, Jeffrey B. Dembo, DDS, testified that the use of Ms. Jacobs was merely as "a scribe to document vital signs on the anesthesia record," Dr. Gilbert's testimony is taken as more credible on the matter since he was on site while Dr. Dembo testified without personal knowledge of the matter. It is therefore found that Ms. Jacobs role was intended to be an anesthesia monitor and that she was attempting to function as such on that date.

14. It is particularly noted that Ms. Jacobs was initially unable to provide proof of a Basic Life Support (BLS/CPR) Certification to the Board as would be required to be an anesthesia monitor. Respondent's office did provide a BLS/CPR Certification Card for Ms. Jacobs, but such card was

issued on March 15, 2006. This apparent attempt to provide partial documentation for Ms. Jacobs to serve as an anesthesia monitor after the fact of the March 3, 2006, site visit further supports a finding that Ms. Jacobs was intended to be by Respondent and did function as an anesthesia monitor on March 3, 2006, as observed by Dr. Gilbert.

15. It is therefore found from the record that the Respondent did knowingly utilize Ann Jacobs, a dental assistant, as an anesthesia monitor at a time when Ms. Jacobs had not fulfilled the requirements of the Board as a monitor and could not provide proof of a Basic Life Support (BLS/CPR) Certification upon request of the Board, all of which as charged in Paragraph 7 of the Statement Of Charges.

16. As to the issue of whether or not the Respondent knowingly used dental assistants who had not taken the Board-required nitrous oxide monitoring course or received a certificate for such procedures from the Board, this allegation is based upon observation by members of the Anesthesia Committee of the Board during a March 3, 2006, site visit to Respondent's Morgantown office. That observation was that nitrous oxide tanks were present in Respondent's office, that the office was plumbed for nitrous oxide use, that the tanks were turned on every day, and that there was no nitrous oxide scavenging system. From that information, the Board inferred that nitrous oxide was in use in that office. The allegation is based on the inference that Respondent's staff had not taken the Board-required nitrous oxide monitoring course or received a certificate for such procedures from the Board. (Paragraph 7(d) of Statement of Charges.)

17. It cannot be found from evidence adduced at hearing that Respondent used nitrous oxide during any procedure of record in this proceeding. The allegation cannot therefore be sustained. Assuming, however, that nitrous oxide is not being used in Respondent's office, it is

found that the practice of Respondent to maintain nitrous oxide in his office, to maintain the plumbing for use of that nitrous oxide, and to cause or permit staff to turn on the tanks on a daily basis when staff is not qualified to use nitrous oxide would cause concern to any professional observer and reflects negatively upon the operation of Respondent's office.

18. It therefore cannot be found from the evidence adduced at hearing that Respondent did, during procedures in which nitrous oxide was used, knowingly use dental assistants who had not taken the Board-required nitrous oxide monitoring course not received a certificate for such procedures from the Board, all of which as was charged in Paragraph 7(d) of the Statement of Charges.

19. The Board has alleged that on April 20, 2006, it was found during an unannounced inspection of Respondent's Fairmont office by members of the Anesthesia Committee that the manufacturer's expiration date on a vial of the drug "Narcan" had been altered by the expiration date having been written over in longhand thereby voiding the pedigree of the medication (Paragraph 8 of the Statement Of Charges). It is apparent that such longhand writing obscured the printed expiration date, but Respondent has suggested that such writing was intended to indicate an expiration date that was faded or illegible.

20. It is therefore found from the evidence adduced at hearing that the manufacturer's expiration date on a vial of the drug "Narcan" had been altered by the said expiration date having been written over in longhand as charged in Paragraph 8 of the Statement Of Charges because regardless of the intent of such handwriting, such writing made it impossible to determine the true expiration date and therefore "altered" the same.

21. As to the allegation that Respondent administrated Versed and Fentanyl in dosages that were construed to be excessive for a 30 to 40 minute procedure, especially without documented incremental dosing and particularly in the cases of two patients identified as BS and DS (Paragraphs 9 and 10 of the Statement Of Charges), this allegation is based upon observations of members of the Anesthesia Committee during an unannounced site inspection/visit to the Fairmont office of the Respondent on February 28, 2006.

22. The report of the February 28, 2006, site visit (included in Complainant's Exhibit 2) indicates that:

> During the process, the committee members observed and found no evidence of graphic representation for dose response incremental dosing of intravenous medications . . . Versed and Fentanyl.

The report further noted that the committee members

> question the usage of intravenous Versed in the 12.5-20 mg dosage range in conjunction with Fentanyl 100 mcg during a 30-40 minute procedure. Dosages greater than 12.5 mg of Versed may be construed to be excessive by some practitioners. The committee members recommended maximum dosages of Versed to be in the 7.5 - 10 mg range for a 30-40 minute procedure.

23. The evidence of record indicates that the issue of concern to the Committee members was whether the intravenous medications were being given in a bolus fashion or in incremental dosing. The concern of the Committee members was that the documentation of dosage by Respondent in the cases reviewed appeared to reflect a bolus dosage when, in fact, it was more likely that Respondent was administering the medications in incremental dosages.

24. The conclusion of bolus dosages from a review of the documentation of the Respondent was recognized by Dr. Dembo, the expert witness for Respondent. He noted in his testimony that:

> The record as it stands would tend to make one believe that the entire 20 milligram bolus was given at the time indicated. As indicated by Dr. Bryant's testimony, that is when the first dose was given of what was multiple incremental doses over the course of the case.

(Vol. II, Transcript, at 272-73.)

25. The Respondent also recognized that from his documentation at that time that it would appear that he was administering a bolus dosage rather than incremental dosage. (See Vol. II Trans. at 104-108.)

26. It is therefore found from the record that the Respondent was, as of the February 28, 2006, site visit, documenting his administration of Versed and Fentanyl in such a manner that dosages would be construed to be excessive for a 30 to 40 minute procedure, especially without documented incremental dosing, all of which as was charged in Paragraphs 9 and 10 of the Statement Of Charges.

27. As to the allegation that the Respondent prescribed controlled substances and sedatives for chronic pain in a neglectful manner and not within conventional guidelines for chronic pain management in that he habitually prescribed controlled substances to multiple members of a single family without rendering treatment (Paragraphs 11 and 12 of the Complaint), this allegation is based upon a review of patient records by Complainant expert Daniel E. Becker, DDS.

28. In his report of December 16, 2006 (Complainant Exhibit 3), Dr. Becker addressed the family in question: i.e., the Chefren family. In his report, he commented and opined as follows:

> Finally, lets consider the Chefren family. There is a fine line between appropriate management of chronic pain and fostering addictive drug behavior. Even taking the most lenient view of this surgeon's prescribing, i.e., management of chronic pain disorders, he cannot justify chronic prescribing of abusable substances to multiple members of a single family. In this case, additional family members should have been referred to different healthcare providers for management of their conditions.

To manage several members of a family in this manner is an egregious violation of ethical practices.

29. Complicating and compounding this issue is the fact that Beverly J. Chefren is both a member of that family as well as a member of Respondent's staff. In addition, evidence in the form of testimony of Dr. Gilbert indicates that Respondent and Ms. Chefren had a personal relationship of a nature that they vacationed together on at least one occasion. (See Gilbert testimony at Vol. III, Transcript at 117-18.)

30. Further complicating this issue is that during the March 3, 2006, site visit there was an apparent attempt on the part of some person or persons in Respondent's office to prevent the review of the file of that same Beverly J. Chefren by Dr. Gilbert. As described in his testimony both on direct (at Vol. I at 207-08) and in rebuttal (at Vol. III at 121-22), that file was removed from a stack being reviewed by Dr. Gilbert, and returned only the following day. In addition, Dr. Gilbert noted that when he first observed the file (but before reviewing it and prior to its removal from the stack of files to be reviewed) it had "[t]wo or three pages in the whole chart," but that "[w]hen the chart was Fed Exed to me the next day, it had 10 or 15 pages in it." (Vol. III, Trans. at 122.)

31. Respondent's expert witness, Dr. Dembo, testified that he saw no ethical violation is Respondent's prescriptions to the said family. (Vol. II, Trans. at 276-79.) However, Dr. Dembo did testify as to the Chefren family that "in view of some prescriptions that may have been written and with the reporting of them not being found, that would be another weakness" and further testified that his "personal choice" would be to not treat "an office assistant who I work with every day for my own fear of not being able to remain objective . . . ." (Vol. II. Trans. at 291.)

32. In his testimony, Respondent described various and wide-ranging medical conditions of members of the Chefren family that justified his prescribing of the medications in question. (Vol. II, Trans. at 116-25.) Respondent's testimony indicated that his personal knowledge, experience and relationships with members of that family went far beyond that of a treating practitioner. He testified that as to Beverly Chefren, she was unable to afford treatment by practitioners for ailments such as Raynaud's Syndrome, fibromyalgia, degenerating discs in her neck, and "a lot of female issues . . . ." (Vol. II, Trans. at 123-24.) He further testified that he was trying to

> help[ing] her [i.e., Beverly Chefren] out so she could afford it, because otherwise she wouldn't be able to go see another surgeon and pay for it. I did what I felt was necessary to keep her function.

(Vol. II, Trans. at 124-126.)

33. Respondent testified that his involvement with the medical issues of Beverly Chefren and her family does not interfere with his looking at her objectively. (Vol. II, Trans. at 125.) He denied any ethical violation in treating the members of the Chefren family, but noted that "it would be different if they were my immediate family." (Vol. II, Trans. at 126.)

34. From the evidence adduced at hearing, it is concluded that Respondent did conduct an unethical medical relationship with the Chefren family in that he prescribed medications to that family on a subjective, rather than professional, basis out of his personal concern and involvement with that family for their various medical concerns. Furthermore, a number of the medical conditions described by Respondent as justification for his prescribing medications do not appear to be entirely appropriate for treatment by a dentist. Finally, the apparent attempt to withhold the Beverly Chefren file from Dr. Gilbert and the apparent supplementing of that file prior to its being

finally provided to the Board suggests some sensitivity by Respondent's office to the Chefren family situation.

35. It is therefore found that Respondent did prescribe controlled substances and sedatives for chronic pain in a neglectful manner and not within conventional guidelines for chronic pain management in that he habitually prescribed controlled substances to multiple members of a single family without rendering treatment, all of which as charged in Paragraphs 11 and 12 of the Complaint.

36. The allegation that Respondent's record-keeping demonstrated incidences of inadequate record-keeping that reflected breaches in the standard of care with regard to proper patient management in that, specifically, (i) Respondent failed to record oxygen saturations of the patient on the anesthesia Record; and (ii) Respondent was negligent in recording the start time of administering anesthesia and the patient's vital signs (Paragraph 13 of the Statement of Charges) was based upon a review of various patient records of Respondent's by members of the Anesthesia Committee, and in particular upon a review and report by Daniel E. Becker, DDS, an expert witness for the Board.

37. Dr. Becker's written reports (see Bd. Ex. 3) and hearing expert opinion testimony addressed the allegations in the Statement of Charges relating to Dr. Bryant's treatment of chronic pain patients utilizing opioid pain medications.

38. Dr. Becker testified that he reviewed various compilations of office records from Respondent's office along with pharmacy printouts and ledgers from the West Virginia Board Of Pharmacy and submitted a summary opinion based on that review. From that review, Dr. Becker concluded that although the amount of opioids prescribed by Respondent were within limits of

published maximum dosage, "the period of time over which the prescriptions were reissued indicated that Respondent was supporting patient abuse or he was managing chronic, rather than acute, pain disorders." (See Bd Ex. 3.)

39. In his report, Dr. Becker opined that Respondent was inappropriately prescribing opioids for chronic pain, that the Respondent's prescribing practice was careless, and that Respondent did not follow conventional guidelines for chronic pain management.

40. In his report, Dr. Becker further opined that "[m]ost certainly the manner in which this surgeon [the Respondent] kept records is well below the expected standard." He further noted that he attempted "to make correlations using the patient records but they are in such disarray that I became discouraged and gave up," and that "the surgeon's records do not adequately reflect the medications prescribed." (Bd. Ex 3 at 1.)

41. In his testimony, Dr. Becker testified that he found Respondent's records "were inadequate and disorganized, far below what is expected in terms of standard of practice." He further testified that Respondent's record-keeping was "pretty impressive as far as disorganized recordkeeping," and described Respondent's files as containing "myriad pieces of paper . . . thrown in the patient's file." (Vol. I, Trans. at 28-29.)

42. Respondent's expert witness, Dr. Dembo, reviewed the matters of record in this case and prepared a letter (Respondent's Ex. 8) in which he offered his opinion as to Respondent's ability to practice safely and in a manner consistent with the standard of care. In that letter, Dr. Dembo opined that Respondent did possess the knowledge and skills to competently practice his speciality and that there was no evidence of gross ignorance or gross inefficiency in Respondent's practice. Dr. Dembo did further opine, however, that there "are some issues regarding Dr. Bryant's practice where

the minimal acceptable standards were not always met" and offered an example of such the issues of recordkeeping as raised by the Statement of Charges in this case. In his letter, Dr. Dembo agreed with Dr. Becker that Respondent's "documentation regarding treatment of some of the patients with TMD and chronic pain were less than expected . . . " but asserted that "insufficient documentation does not necessarily indicate insufficient quality of care." (Respondent's Ex. 8, pp. 5-6.)

43. In his testimony, which was offered after he had reviewed prior hearing testimony given by Dr. Becker, Dr. Gilbert, Dr. Richard Marshall and Susan Combs, Dr. Dembo stated, under cross-examination, that Respondent's documentation was "a little difficult to read from one note to the next . . . ," that "it is a little difficult sometimes to read the handwriting," and that "the sequence of treatment was a little difficult to decipher." (Vol. II Trans. at 290-91.)

44. From the evidence adduced at hearing, it is concluded that Respondent's record-keeping did demonstrate incidences of inadequate record keeping that reflected breaches in the standard of care with regard to proper patient management in that, specifically, (i) Respondent failed to record oxygen saturations of the patient on the anesthesia Record; and (ii) Respondent was negligent in recording the start time of administering anesthesia and the patient's vital signs, all of which as charged in Paragraph 13 of the Statement of Charges.

CONCLUSIONS OF LAW

1. The West Virginia Board of Dental Examiners has jurisdiction over this matter. See West Virginia Code § 30-4-1, et seq.

2. Respondent James G. Bryant is a licensee of the West Virginia Board of Dental Examiners and is subject to license requirement of the Board.

3. This matter is properly before the undersigned hearing examiner for evidentiary hearing and submission of recommended findings of fact and conclusions of law to the Board for its consideration.

4. The Board has the power to revoke a license, place a license on probation, suspend the license, reprimand the licensee or take other disciplinary action under West Virginia Code § 30-4 1, et seq. and the rules promulgated thereunder.

5. The provisions of West Virginia Code § 30-4-20(a) provide that the Board may refuse to issue, refuse to renew, suspend or revoke any license or practice privilege of a licensee and may take disciplinary action against a licensee who, after hearing, has been adjudged as unqualified for any of the following reasons:

> (3) Incompetent, negligent or willful misconduct in the practice of dentistry or dental hygiene, which shall include the departure from, or the failure to conform to, the minimal standards of acceptable and prevailing dental or dental hygiene practice in their area of expertise as shall be determined by the board. The board need not establish actual injury to the patient in order to adjudge a licensee guilty of this conduct.
>
> (4) Engaging in conduct that indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry or dental hygiene.

6. The Statement Of Charges in this case alleged that the Respondent knowingly utilized Ann Jacobs, a dental assistant, as an anesthesia monitor at a time when Ms. Jacobs had not fulfilled the requirements of the Board as a monitor and could not provide proof of a Basic Life Support (BLS/CPR) Certification upon request of the Board, all of which as was charged in Paragraph 7(a)-(c) of the Statement Of Charges. It is found that the said allegation should be sustained as a violation of the provisions of West Virginia Code §§ 30-4-20(a)(3) and (4).

7. The Statement Of Charges in this case alleged that during procedures in which nitrous oxide was used, the Respondent knowingly used dental assistants who had not taken the Board-required nitrous oxide monitoring course and had not received a certificate for such procedures from the Board, all of which as was charged in Paragraph 7(d) of the Statement of Charges. It is found that the allegation should not be sustained.

8. The Statement Of Charges in this case alleged that on April 20, 2006, an unannounced inspection of Respondent's Fairmont office by members of the Anesthesia Committee discovered that the manufacturer's expiration date on a vial of the drug "Narcan" had been altered by the said expiration date having been written over in longhand, thereby voiding the pedigree of the medication, all of which as was charged in Paragraph 8 of the Statement Of Charges. It is found that the said allegation should be sustained as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

9. The Statement Of Charges in this case alleged that during a February 28, 2006, unannounced site inspection/visit to Respondent's Fairmont office by members of the Anesthesia Committee, it was observed that Respondent administrated Versed and Fentanyl in dosages that were construed to be excessive for a 30 to 40 minute procedure, especially without documented incremental dosing, all of which as was charged in Paragraphs 9 and 10 of the Statement Of Charges. It is found that the said allegation should be sustained as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

10. The Statement Of Charges in this case alleged that the Respondent prescribed controlled substances and sedatives for chronic pain in a neglectful manner and not within conventional guidelines for chronic pain management in that he habitually prescribed controlled

substances to multiple members of a single family without rendering treatment, all of which as was charged in Paragraphs 11 and 12 of the Complaint. It is found that the said allegation should be sustained as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

11. The Statement Of Charges in this case alleged that a review of various patient records by members of the Anesthesia Committee demonstrated incidences of inadequate record-keeping that reflected breaches in the standard of care with regard to proper patient management in that, specifically, (i) Respondent failed to record oxygen saturations of the patient on the anesthesia Record; and (ii) Respondent was negligent in recording the start time of administering anesthesia and the patient's vital signs, all of which as was charged in Paragraph 13 of the Statement of Charges. It is found that the said allegation should be sustained as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

PROPOSED ORDER

It is recommended as follows as to the complaint against Respondent James G. Bryant:

1. That the allegation that the Respondent knowingly utilized Ann Jacobs, a dental assistant, as an anesthesia monitor at a time when Ms. Jacobs had not fulfilled the requirements of the Board as a monitor and could not provide proof of a Basic Life Support (BLS/CPR) Certification upon request of the Board, all of which as was charged in Paragraph 7(a)-(c) of the Statement Of Charges, be **SUSTAINED** as a violation of the provisions of § 30-4-20(a)(3) and (4).

2. That the allegation that during procedures in which nitrous oxide was used the Respondent knowingly used dental assistants who had not taken the Board-required nitrous oxide monitoring course and had not received a certificate for such procedures from the Board, all of which as was charged in Paragraph 7(c) of the Statement of Charges, be **NOT SUSTAINED**.

3. That the allegation that on April 20, 2006, an unannounced inspection of Respondent's Fairmont office by members of the Anesthesia Committee discovered that the manufacturer's expiration date on a vial of the drug "Narcan" had been altered by the said expiration date having been written over in longhand, thereby voiding the pedigree of the medication, all of which as was charged in Paragraph 8 of the Statement Of Charges, be **SUSTAINED** as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

4. That the allegation that during a February 28, 2006, unannounced site inspection/visit to Respondent's Fairmont office by members of the Anesthesia Committee, it was observed that Respondent administrated Versed and Fentanyl in dosages that were construed to be excessive for a 30 to 40 minute procedure, especially without documented incremental dosing, all of which as was charged in Paragraphs 9 and 10 of the Statement Of Charges, be **SUSTAINED** as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

5. That the allegation that the Respondent prescribed controlled substances and sedatives for chronic pain in a neglectful manner and not within conventional guidelines for chronic pain management in that he habitually prescribed controlled substances to multiple members of a single family without rendering treatment, all of which as was charged in Paragraphs 11 and 12 of the Complaint, be **SUSTAINED** as a violation of the provisions of West Virginia Code §§ 30-4-20(a)(3) and (4).

6. That the allegation that a review of various patient records by members of the Anesthesia Committee demonstrated incidences of inadequate record keeping that reflected breaches in the standard of care with regard to proper patient management in that, specifically, (i) Respondent failed to record oxygen saturations of the patient on the anesthesia Record; and (ii) Respondent was

negligent in recording the start time of administering anesthesia and the patient's vital signs, all of which as was charged in Paragraph 13 of the Statement of Charges, be **SUSTAINED** as a violation of the provisions of West Virginia Code § 30-4-20(a)(3) and (4).

The West Virginia Board of Dental Examiners is the State entity vested with the power to regulate the profession of Dentistry in West Virginia. W. Va. Code § 30-4-1 et seq. (the "Dental Practice Act"). As such, the agency's interpretation of its own regulations is entitled to substantial deference. Chevron USA v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984); Owen Electric Steel Co. of South Carolina, Inc. v. Browner, 37 F.3d 146, 148 (4th Cir. 1994); Georgia Dept. of Medical Assistance v. Shalala, 8 F.3d 1565, 1567 (8th Cir. 1993). Extending such deference, it is found that the interpretation by the Board of applicable statutes would receive similar deference. Under the circumstances of the facts as established by the record of this matter, with Respondent being subject to a consent decree after the death of one of his patients under anesthesia, vigorous exercise of such authority would be justified and necessary to carry out the intent of the Act. It is therefore found that the interpretation and enforcement of the Act by the Board in this case constitutes a reasonable exercise of the authority and the discretion of that Board.

It is recommended that the West Virginia Board of Dental Examiners impose appropriate sanctions for the allegations sustained.

RECOMMENDED THIS 18th DAY OF February, 2009.

JACK C. McCLUNG
HEARING EXAMINER