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STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF DENTISTRY

IN THE MATTER OF THE SUSPENSION :
OR REVOCATION OF THE LICENSE OF

PATRICK BAMGBOYE, D.D.S.
License No. 22DI02068800

: Administrative Action

: FINAL ORDER

TO PRACTICE DENTISTRY :
IN THE STATE OF NEW JERSEY :

The New Jersey State Board of Dentistry enters this Final Order following its review of the Initial Decision of the Honorable J. Howard Solomon, A.L.J. This matter concerns the sudden death of a six year old, severely medically compromised child during elective dental treatment. The Board, after a thorough review of the record and in the exercise of its expertise regarding the practice of dentistry in this State, has determined to modify the findings of fact and conclusions of law and reject the decision of Judge Solomon dismissing the complaint. The Board takes this action because Judge Solomon's decision addressed only some of the allegations in the administrative complaint. He did not address, and made no findings or conclusions on, the allegations that the dentist's conduct constituted repeated acts of negligence and violated the Board's rules on record keeping. The Board's careful review of the record reveals facts that fully support the Board's conclusion that those allegations have been proven and that respondent's conduct forms the basis for discipline.

Procedural History

On March 3, 2008, the Attorney General (“Attorney General” or “complainant”) filed an Administrative Complaint against Dr. Patrick Bamgboye, D.D.S. (“Dr. Bamgboye” or “respondent”). The Attorney General alleged that respondent’s failure to provide proper dental care to K.P.¹ constituted, alternatively, repeated acts of negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21 (d) and/or gross negligence, incompetence or malpractice in violation of N.J.S.A. 45:1-21 (c); and that his failure to document assessment and care constituted a violation of N.J.A.C. 13:30-8.7 and N.J.S.A. 45:1-21 (h). In response to the complaint, respondent, through counsel, filed an Answer on March 8, 2008 denying the allegations.

On April 16, 2008, the Board deemed the matter a contested case and transferred it to the Office of Administrative Law (“OAL”). N.J.S.A. 52:14B-2 (b). Judge Solomon conducted the hearing on January 25, 26, 28, and 29, 2010. On May 4, 2010, finding no gross negligence on respondent’s part, but not addressing the allegations of repeated acts of negligence, malpractice or incompetence, and the issues related to record keeping, he issued his Initial Decision dismissing the complaint. The Attorney General, within the time permitted by N.J.S.A. 52:14B-10 (c), filed limited exceptions to Judge Solomon’s decision. N.J.A.C. 1:1-18.4. Dr. Bamgboye, through counsel, disputed the exceptions and urged the Board to adopt the Initial Decision.

On July 21, 2010, the Board heard arguments of counsel on the exceptions. Following a thorough review of the record, the Board determined to modify and reject the

¹ The administrative law judge permitted the patient’s initials to be used to protect her and her family’s privacy. The Board has continued that practice here.

Initial Decision, finding that respondent, in his decision to treat, and in his treatment of, K.P. in February 2004, had engaged in repeated acts of negligence and had violated the Board's regulations with regard to record keeping. It continued the matter to provide respondent with an opportunity to present evidence in mitigation of any sanction to be imposed. On September 1, 2010, the Board conducted a mitigation hearing at which Dr. Bamgboye testified and offered letters attesting to his character and competence. The Attorney General submitted an application for costs associated with the investigation and prosecution of the matter, as well as for attorney's fees. Respondent's counsel orally objected to the application stating that he had not had an opportunity to meaningfully review the application. Finally, respondent's counsel asked that if the Board did impose any discipline, that it stay its order pending appeal.

The Board, after deliberations, ordered that Dr. Bamgboye's license to practice be suspended for a period of two years, three months of which is to be served as an active suspension and the remainder served as a period of probation. The Board directed that Dr. Bamgboye pay a penalty of \$10,000 and complete certain remedial continuing education. The Board granted respondent an opportunity to submit objections to the application for fees and costs and indicated that it would review that application at its meeting on October 20, 2010. Lastly, the Board denied the application for a stay of its order, noting the Final Order imposing discipline would be entered after the October meeting and the active portion of the suspension would begin twenty-one days after entry of the Final Order. Respondent, within the time directed, did not submit any materials objecting to the fees and costs sought by the Attorney General. On October 20, 2010, the Board granted the application for costs and fees without modification.

FACTS IN THE RECORD

In its review of the record, the Board has determined to adopt most of Judge Solomon's findings.² But because many of the details relating to the treatment of K.P. are not mentioned in the decision of the A.L.J., the Board expands upon those findings, including essentially undisputed facts that are critical to an understanding of this case.

On February 24, 2004, K.P., a six year old, medically compromised patient, was brought by her mother to the dental office of Dental Health Associates. Due to her failure to thrive, K.P. appeared much younger than her stated age, weighing only 33 pounds - the size of a three year old. K.P. suffered from cerebral palsy, dysphagia, and a seizure disorder, was mentally retarded and unable to communicate. A naso-gastric (feeding) tube had been placed in December 2003; her stomach was distended and she was congested. (Exhibits P-1 and J-1)

K.P. had been to the dental office in August 2003, at which time she had an examination, a prophylaxis (cleaning), and a fluoride treatment. Although scheduled to return for treatment in September of that year, she missed the appointment. She was appointed for a recall examination on February 24, 2004. Because her paper chart had been misplaced, K.P.'s mother was asked to complete a new medical history form, which

² As urged by the Attorney General, the Board specifically rejects Findings 38 and 39 (Initial Decision, pp 29-30). Additionally, the Board modifies Finding 40, in which the ALJ cites to Dr. Brunsdon's testimony that he would not classify K.P. as a high risk patient if her seizures had been controlled and if she did not have liver disease. That finding does not accurately reflect the colloquy and is not supported by Dr. Brunsdon's testimony when viewed in its entirety. (January 26, 2010, T11:3 to T13:5). Indeed, both experts who testified would have classified K.P. as an ASA III patient, that is "a patient with severe systemic disturbance o disease." (See discussion p. 10 below).

she did with the assistance of an interpreter. On that portion of the form listing over forty medical conditions, the mother checked "liver disease." Although she noted K.P. was taking "trileptal (for seizure)," she did not check "seizures" on the form. (Seizures was listed immediately below liver disease on the form.) The dental assistant who was translating information, on a separate sheet in the record, hand wrote "liver disease" in the area for "Significant Medical History."

Dr. Bamgboye, a pediatric dentist in the practice testified that he reviewed limited computer records available from K.P.'s prior visit, spoke to her mother regarding some aspects of K.P.'s medical condition, performed an examination on K.P., and discussed the condition of K.P.'s dentition (which had deteriorated since her visit in August 2003) and the treatment to be rendered. According to his testimony, Dr. Bamgboye asked her mother about K.P.'s distended abdomen and was told it was a normal condition for K.P. He testified that he asked whether K.P. had been given Trileptal that day and was told she had. He did not ask any questions regarding the notation "liver disease," though he maintained that during his examination of K.P. he had checked her eyes for any indication of jaundice.

Dr. Bamgboye initially planned to treat K.P. over three appointments. As K.P.'s condition precluded her from cooperating in treatment, and because she lacked muscle control, Dr. Bamgboye placed her in a papoose (a backboard with velcro straps that is commonly used with pediatric patients to prevent them from moving about during treatment). Dr. Bamgboye performed a prophylaxis, at which point K.P.'s mother, who was present in the operatory, asked him if he would continue to treat her daughter as she

related K.P. was experiencing pain.³ Respondent then administered local anesthesia (lidocaine with epinephrine), placed a rubber dam, and restored (filled) two teeth on the upper right. He then began pulpotomies on the three teeth on the lower right. During this period, because K.P., obviously distressed as evident by her continuous screaming and crying, K.P.'s mother asked Dr. Bamgboye to stop treatment. Dr. Bamgboye explained to her that because the teeth had by then been prepared for crowns, it was necessary to proceed to cover the teeth to prevent infection. K.P.'s mother acquiesced and agreed to continue treatment.

While he was preparing crowns for placement on those teeth, K.P.'s mother and a dental assistant present in the operatory alerted respondent that K.P.'s lips were blue. Dr. Bamgboye checked for respiration, and finding none, removed the papoose, and started cardio-pulmonary resuscitation. As he gave K.P. mouth-to-mouth breaths first without and then with an airway, a second dentist was called and began chest compressions. Emergency Medical Service personnel arrived and transported K.P. to the hospital where, that evening, she was pronounced dead. As reflected in the Final Autopsy Report, "Cause of Death: Sudden death during dental procedure. Chronic seizure disorder due to severe cerebral palsy. Manner of Death: Natural." (Exhibit J-4 Bates-stamp 152).

As required by N.J.A.C. 13:30-8.8, respondent, through counsel, submitted a signed incident report, notifying the Board that K.P. had been removed from the dental office to a hospital and had died. In that report, excerpted here, which was prepared

³ Respondent also testified that K.P.'s mother said K.P. was in pain during his initial discussion with her. That initial disclosure apparently did not cause him to alter his plan to treat K.P. over a series of visits.

within hours of the incident, he related:

Patient came in with mother complaining of the child having pain but no fixed location because the child could not talk.

Observation: child was congested and had a distended stomach. Mom said this was normal with her. Has facial rashes on both cheeks, a stomach tube and in diapers.

MEDICAL HISTORY: A feeding tube was placed in December 2003. She is on Trileptal for seizures. She is physically handicapped.

(Exhibit P-1 in evidence)

THE ATTORNEY GENERAL'S COMPLAINT

The Administrative Complaint filed in March 2008 focused on Dr. Bamgboye's decision to treat K.P. on February 24, 2004, noting that he had not consulted with her treating physician despite her severe medical conditions, that he erred in evaluating her ability to tolerate extensive treatment, as evidenced by his assessment of K.P. as an ASA II patient, rather than an ASA III patient⁴; that he failed to ensure appropriate emergency equipment was available; and that he did not provide sufficient information to K.P.'s mother to permit her to make an informed decision as to treatment options. The complaint also alleged inadequate record keeping. Respondent denied the allegations and the matter was transmitted to the OAL as a contested case.

HEARING AT OFFICE OF ADMINISTRATIVE LAW

At the hearing before Judge Solomon, the Attorney General presented one

⁴ The American Society of Anesthesiologists (ASA) classifies patients for purposes, including but not limited to determining the appropriate treatment, location, and circumstances for administering anesthesia. Dr. Cavin Brunsten, the State's expert, testified that the classification system is used in dentistry to determine whether a patient can withstand the rigors of the dental care to be provided. (January 26, 2010 T6:19-22)

witness, Cavan Brunsten, D.M.D. Dr. Brunsten is Board certified by the American Academy of Pediatric Dentistry (AAPD), and holds a specialty permit in pediatrics issued by this Board. He has a private dental practice in Old Bridge, New Jersey, and has taught on occasion at the New Jersey Dental School regarding providing care to children with special needs. He has lectured to pediatric dentists at national meetings of the AAPD. Dr. Brunsten is familiar with the AAPD guidelines as well as New Jersey's laws and regulations governing dental practice in this State. Based on his experience as both a practitioner and an educator, he was accepted as an expert in the field of pediatric dentistry without objection.

Dr. Brunsten testified that he was familiar with the practices of other pediatric dentists and the standard of care they follow. Dr. Brunsten stated the standard of care is found in the curriculum for graduate education in pediatric dentistry that is established by the American Academy of Pediatric Dentistry. That curriculum is supplemented by continuing education as well as the AAPD's Handbook and Guidelines, which reflect cumulative research and represent expertise in the field. (January 26, 2010 T15:21-T16:13) He noted the guidelines "are designed to provide the best of care to the patient, as well as provide doctors with guidelines to maintain the integrity of what they do." (January 25, 2010 T29:13-16). Though the Guidelines themselves contain a disclaimer that they do not establish a standard of care, Dr. Brunsten stated the Guidelines are regularly used to teach pediatric dentistry and are followed by practitioners to maintain the level of professionalism and to protect the health of the patient. In treating medically compromised patients, the standard of care for pediatric dentists is further informed by the Guidelines, and additional training dentists avail themselves of, including continuing

education, attendance at conferences, and reading professional publications and texts.

(January 25, 2010 T30:15 - T31:7)

Dr. Brunsdon testified that when a patient presents as K.P. presented – unable to communicate, severely medically compromised - the standard of care for a pediatric dentist in New Jersey includes as an essential element that the dentist take a comprehensive medical and dental history from the child's parent or guardian to fully assess the child's ability to proceed with treatment. Following an oral examination, the dentist determines various treatment options and from those options the most appropriate course of treatment for the patient considering the patient's dental needs (for example, emergency or elective care) and the medically compromised patient's ability to tolerate the treatment. The parent or guardian should understand the options and be given help in deciding which option is in the best interest of the child.

Where a medical history is complex, with multiple health care issues so significant as to potentially compromise the treatment to be rendered, Dr. Brunsdon testified that seeking a medical consultation with the patient's treating physician to have a more complete understanding of the patient's condition is advisable. In his expert opinion, and based on his knowledge of the standards governing pediatric dentists in New Jersey, Dr. Brunsdon testified that respondent should have more fully discussed K.P.'s medical history with her mother and consulted K.P.'s treating physician(s). While he recognized that there is no requirement in the Guidelines that a dentist contact a treating physician (it is within the treating dentist's discretion), Dr. Brunsdon noted that given K.P.'s myriad medical conditions and their effect on her body, a consult was indicated and that it would be the standard among pediatric dentists in New Jersey to do so under these

circumstances.

Dr. Brunsten also identified options that a dentist may elect after his assessment of the patient, including admit the patient to a hospital so treatment could be rendered under sedation; palliative treatment, for example, prescribing antibiotics and pain medication until a time when the patient was better able to tolerate more extensive treatment; or refer the patient to a different dentist or to an oral surgeon; or again, considering all relevant factors (including patient's condition, emergent vs. elective care), elect to treat the patient. The decision to treat depends on the patient's presenting medical condition and the extent of treatment necessary.

In discussing patient assessment, Dr. Brunsten referred to the American Society of Anesthesiology (ASA) classification system for determining a patient's level of tolerance for anesthesia, including its use with medically compromised patients. While Doctor Bamgboye had not used sedation in his treatment of K.P., he noted the classification system in dentistry is a helpful tool in assessing an individual's ability to tolerate treatment. Those classifications are:

Class I: a normally healthy patient with no organic, physiologic, biochemical or psychiatric disturbance or disease.

Class II: a patient with mild-to-moderate systemic disturbance or disease.

Class III: a patient with severe systemic disturbance or disease.

Class IV: a patient with severe and life threatening systemic disease or disorder.⁵

⁵ There are two additional ASA classifications: "Class V: a moribund patient who is unlikely to survive without the planned procedure," and "Class VI: a patient declared brain-dead whose organs are being removed for donor purposes."

[Exhibit J-7; Bates-stamped page181]

Dr. Brunsten testified that he would have classified K.P. as an ASA III patient, many of whom, given complex medical histories, are treated under sedation.

Addressing respondent's assessment of K.P., including Dr. Bamgboye's assessment that she was an ASA II patient, Dr. Brunsten discussed the paucity of information in the patient's chart, which reflected an inadequate evaluation of information and, therefore, an inadequate assessment. The chart did not contain notes regarding salient aspects of K.P.'s medical history, including any discussion of her presenting conditions of congestion, a distended abdomen, the side effects of her cerebral palsy such as her uncontrolled limb movements, inability to communicate, and mental retardation. The chart did not indicate the dose or the time of Trileptal that K.P. was said to have taken. Notably, the chart did not reference any discussion of the checked-off "liver disease" or the notation "liver disease" in the area captioned "Significant Medical History." (Exhibit J-1, Bates-stamped 087-088). Among other omissions, the chart did not note any treatment alternatives that were presented to K.P.'s mother, nor did it reflect the reason for the visit - a recall visit (as listed in the appointment book and supported by Dr. Bamgboye's original plan to treat over three visits) or an emergency visit (because the patient was in pain).

Dr. Brunsten also testified that the standard form for informed consent used by Dr. Bamgboye was less comprehensive than that used in 2004 by pediatric dentists in New Jersey who were treating medically compromised patients. Review of this so-called informed consent (Exhibit J-1 Bates-stamped 090-091) signed by K.P.'s mother shows it to be a paragraph at the end of the "Treatment Plan Estimate." It is very general in

nature; it does not reflect additional considerations that are plainly relevant to treatment of medically compromised patients. It does not give the patient or her guardian any indication that treatment for a child with multiple medical conditions may result in complications. In fact, the text of the "informed consent" relates more to the patient's financial obligations than to the treatment to be rendered.⁶

When reviewing Dr. Bamgboye's decision to treat K.P. on that date, without a record that would support a finding that respondent took a comprehensive medical history or that he effectively assessed K.P.'s ability to tolerate treatment, or presented her mother with options, coupled with his decision to proceed without a medical consultation, Dr. Brunsdon offered his opinion that respondent's conduct was negligent and significantly deviated from the recommended course of treatment for a patient as severely medically compromised as K.P. In discussing the record created for K.P., Dr. Brunsdon identified the critical information that was omitted:

A review of the health history with the parent, the details of that review. The medication the child was on; what dose they received when they received it; the statute [sic] of the liver disease; the status of the seizure disorder; the outcome of the most recent hospitalizations in [sic] which there were several in the month of treatment; and the information that should have been provided by the physician relative to all of those items.

⁶ The text reads: "I hereby give full consent to the Dentists at Dental Health Associates (DHA) to provide the above mutually agreed upon routine dental services for myself (my child). Routine services may include, but are not limited, to local anesthetics (injections), other medication, the restraint of uncooperative children. I understand that I am responsible for all costs not paid by any insurance regardless of the reason. I am responsible for all costs of collecting, or attempting to collect any debt owed to DHA including reasonable attorney fees. Account balances after 90 days will be charged a monthly interest rate of 1.5% (18% APR). Notwithstanding insurance coverage, when starting any procedure that requires multiple visits to complete, I am responsible for the full fee at the start of the procedure." (Exhibit J-1, Bates-stamped 091).

(January 25, 2010, T 198:23 to T 199:6)

On cross examination, Dr. Brunsdon responded that individual components of the treatment decisions Dr. Bamgboye made generally fall within the exercise of a dentist's professional judgment (for example, use of a papoose or the decision to continue treatment by placing crowns on teeth that had been opened for pulpotomies). Yet Dr. Brunsdon's expert opinion was that Dr. Bamgboye had significantly deviated from the standard of care based on his view of the treatment of K.P. in its totality.

Respondent presented Dr. Stanley Malamed as his expert witness. Dr. Malamed is a professor at the University of Southern California ("USC") Dental School in Los Angeles. Following his graduation from dental school in 1969, he completed a dental and anesthesia internship. He served in the Army as a dentist before beginning his teaching career at USC's Dental School in the department of anesthesia and medicine. In addition to teaching, Dr. Malamed has served as a clinical consultant for drug companies. He has not practiced clinical dentistry in a private setting. Dr. Malamed is a diplomate of the American Dental Board of Anesthesiology.

Dr. Malamed teaches courses in four areas: anesthesia, sedation, physical evaluation, and emergency medicine. He supervises pediatric dental residents in the dental school when their patients are administered anesthesia. He has appeared as an expert witness both in court matters and before State boards. He has authored three textbooks in the areas of local anesthesia, medical emergencies, and sedation. Dr. Malamed was accepted as an expert in anesthesia, medical emergencies, and in

pediatric dentistry.⁷

When asked specifically about respondent's treatment of K.P., Dr. Malamed testified that Dr. Bamgboye had not deviated from any standard of care, as he contended there were not any established standards in the area of pediatric dentistry. Dr. Malamed acknowledged respondent's medical history and records were deficient, but stated there was not a deviation as dentists keep poor records and do not write down their findings. Dr. Malamed testified that Dr. Bamgboye's decision not to consult with K.P.'s medical doctor was an appropriate exercise of professional judgment as Dr. Bamgboye had experience in treating medically compromised patients.

Although Dr. Malamed testified that he did not believe respondent's course of treatment that day would have been significantly altered had he received a more comprehensive medical history on K.P., including her recent hospitalizations, he acknowledged that he would have probed K.P.'s mother further regarding the possibility of liver disease. Further, he stated that if K.P. did have pneumonia at the time of her treatment, as the autopsy report indicated (Exhibit J-4), that would have changed his course of treatment for K.P. as her heart and lungs would be compromised. In discussing the record prepared by Dr. Bamgboye, Dr. Malamed agreed that dentists should present treatment options to patients and their parents and should record such conversations.

Following the conclusion of Dr. Malamed's testimony, Dr. Bamgboye took the stand. He testified about his decision to treat K.P., the treatment rendered, and the discussions he said he had with her mother. He stated that he was able to obtain a good

⁷ The Attorney General objected to Dr. Malamed as an expert in pediatric dentistry as he is not a pediatric dentist.

medical history from K.P.'s mother. Although Dr. Bamgboye had developed a treatment plan that called for additional visits, and he was prepared to discharge the child after performing a prophylaxis and fluoride application, he decided at the behest of K.P.'s mother to perform additional treatment. His rationale for proceeding was that K.P.'s condition had deteriorated; that the patient may not have returned (based on the missed appointment in September 2003); and his belief that the treatment would not interfere with K.P.'s medication or medical condition. When asked about the presence of congestion, Dr. Bamgboye denied noticing any during his oral and pharyngeal examination and did not recall whether K.P.'s mother had reported any congestion. That testimony is in stark contrast to Dr. Bamgboye's report of the child's condition on the incident report completed hours after K.P. stopped breathing and was taken to the hospital. Dr. Bamgboye noted in that report (Exhibit P-1) that the patient was congested: a fact confirmed by the autopsy report's finding that K.P. had pulmonary congestion and edema and patchy acute bronchopneumonia. (Exhibit J-4, Bates-stamped 149).

Respondent's testimony regarding his decision not to seek a medical consultation prior to treating K.P. mirrored his reasons for proceeding with treatment:

Number one, because of the emergence [sic] of the nature of the procedure that needed to be done that day. Number two, because of the lack of compliance of the parent. Number three, the mother's anxiety. It was something having to be done that day and number four, because the procedure I was trying to accomplish was not going to interfere in any way with either the medication or the patient's condition. [January 28, 2010 T 86:20-T87:5]

But again, Dr. Bamgboye's testimony contradicts the facts. Prior to K.P.'s mother asking him to continue, respondent was prepared to discharge the child. If pain were a consideration, palliative treatment (pain medication and antibiotics for infection) was

available. Further, although Dr. Bamgboye said his treatment decisions were driven by concern the patient's mother was non-compliant, he accepted her version of K.P.'s health history. When confronted with a confusing and incomplete medical history from this supposedly non-compliant parent, he did not adequately follow up. It is the very lack of comprehensive assessment that led him to the faulty -and tragic - conclusion that the treatment he was undertaking on this severely medically compromised patient would "not interfere in any way" with the condition of a thirty-three pound, six year old child with cerebral palsy, a naso-gastric tube, dysphagia, mental retardation, congestion, and a distended abdomen, who, as Dr. Bamgboye admits, was "screaming at the top of her lungs" (January 28, 2010 T74:12-13), and placed in a papoose with a rubber dam in her mouth.

After reviewing the record and evaluating the testimony of both expert witnesses, the Board, employing its own expertise, agrees with Dr. Brunsden's testimony, which recognizes the standard of care for the practice of pediatric dentistry in this State. While the Board acknowledges Dr. Malamed's experience and contributions in the field of dentistry, particularly with regard to dental anesthesia, the Board agrees with Dr. Brunsden, who is a Board certified pediatric dentist practicing in this State, with considerable experience treating medically compromised patients. His testimony that the standard of care is set by the AAPD through its curriculum in graduate programs for pediatric dentistry and through its Guidelines and by pediatric dentists through their practices, as informed by texts, continuing education, and other professional journals, is

accepted by the Board.⁸

Given the Board's familiarity with dental practice in this State and the experience of many of its members as practitioners, in reaching its decision, it has analyzed the testimony of both experts and identified the standard of care against which Dr. Bamgboye's actions are measured. Additionally, as the administrative law judge failed to address all allegations of the administrative complaint, the Board, as permitted by law and in the exercise of its expertise, has reviewed the Initial Decision and the record and has determined from that review that the established facts, may undisputed, support the conclusion that respondent repeatedly deviated from the standard of care.

Respondent's record keeping also fell short of acceptable standards and the Board's regulations. The AAPD Guidelines state that "[a]n accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning." (Exhibit J-7,pg. 135). A medical history should include: "medical conditions and/or illnesses, name and...telephone number of primary and specialty medical care providers, hospitalizations/surgeries,...current medications,...review of symptoms," and be updated at each visit. The Guidelines also recommend that after obtaining that medical history, the dentist should assess the patient's dental condition, including chief complaint and review of radiographs. If a parent or guardian is unable to provide a thorough or reliable medical history, dentists may seek a medical consultation with the patient's primary care physician. The record should reflect that consultation.

In addition to the standards advocated by the AAPD Guidelines, the Board's

⁸ Judge Solomon appears to have equated the lack of a single, written standard of care with "no real set of standards..." Finding Number 39, Initial Decision at p. 30.

regulations in effect in 2004 required that dentists maintain:

(a) A contemporaneous, permanent patient record...for each person seeking or receiving dental services, regardless of whether any treatment is actually rendered or whether any fee is charged...Such records shall include, at a minimum:

*** **

2. The patient's medical history;
3. A record of results of a clinical examination where appropriate or an indication of the patient's chief complaint;
4. A treatment plan;
5. The dates of each patient visit and a description of the treatment or services rendered at each visit.

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[N.J.A.C. 13:30-8.7 (a) (2)-(5)].

While respondent claimed that he spoke with K.P.'s mother (through his dental assistant and translator) for approximately two to four minutes regarding K.P.'s medical history and any changes to it, there is nothing in the patient's record that demonstrates that he addressed the "liver disease" notation. Whether respondent noticed "liver disease" had been checked off while he was treating K.P. (and assumed it was a mistake because he knew she had a seizure disorder) or whether he noticed that it was checked off only after K.P. was removed from the office by ambulance after she stopped breathing, the patient record does not reflect K.P.'s actual condition, making the medical history inaccurate. That she did not in fact have liver disease (as confirmed by the

autopsy report) does not alter Dr. Bamgboye's failure to have further questioned K.P.'s mother. Moreover, had Dr. Bamgboye done so, he likely would have learned that in addition to the December 2003 hospitalization, K.P. had recently been in the hospital for two different, minor procedures: a sweat test for cystic fibrosis and a biopsy. This pertinent medical history is absent in the record, as are vital signs, any notation regarding congestion, the patient's risk assessment, treatment options, and an informed consent that addressed issues related to medically compromised patients. Moreover, the treatment plan, which doubles as an informed consent (Exhibit J-1, Bates-stamped 091), did not include alternatives to treatment or alternative modalities for delivery of care.

The Board recognizes that respondent's treatment record was created contemporaneously with K.P.'s treatment and that an emergency arose before treatment was completed. Respondent testified at the hearing that he did not add to or correct the record following the incident because he thought it would amount to tampering with evidence and look suspicious. (January 29, 2010, 46:10-13). However, nothing in the Board's regulations prevents a practitioner from entering information in the record regarding treatment rendered provided the entry contains the date on which it was written. His failure to record pertinent information therefore is not excused by the emergency.

In addition to the deficiencies in assessment and record keeping, the Board also finds that the record demonstrates that respondent commenced K.P.'s treatment without ensuring that proper pediatric emergency equipment was available. The AAPD Guidelines that Dr. Brunsten cited to when discussing the relevant standard of care for

record-keeping and treatment planning, when addressing sedation, described airway management equipment that should be present when treating a pediatric patient under minimal/moderate sedation.⁹ (Ex. 7, pg. 103). Although K.P. was not given sedation (local anesthesia was used to numb the areas being treated), her multiple and serious medical conditions should have signaled the need to ensure an adverse event could be immediately and effectively addressed. Though the Guidelines do not address treatment under local anesthesia, a dentist who undertakes to treat a patient with cerebral palsy, congestion, a seizure disorder, an N-G tube, and recent hospitalization, while using a papoose and a rubber dam, must be sure that adequate emergency equipment is available. As Dr. Brunsdon testified: "The more severe the medical condition of the child, the more likely they are to have an adverse reaction to elective dental care." (January 26, 2010 T7:5-7). Respondent admitted that he was aware the office lacked certain pediatric life-saving equipment (like an external defibrillator and a pediatric ambu bag) (P-2 , Transcript of March 5, 2005 appearance, T51 through T53).

After carefully reviewing the record, including the testimony of Dr. Brunsdon, Dr. Malamed, and respondent, and the evidence introduced, including the patient record (Exhibit J-1); the incident report filed with the Board pursuant to N.J.A.C. 13:30-8.8 (Exhibit P-1); respondent's testimony at an investigative inquiry conducted by the Board on March 5, 2005 (Exhibit P-2); the Medical Examiner's report (Exhibit J-4, Bates-

⁹ The AAPD defines minimal sedation as a type of sedation used to decrease or eliminate anxiety that does not interfere with the conscious state or their motor functions. (Ex. J-7, Bates-stamped 101). The AAPD Guidelines on airway management equipment for minimally sedated pediatric patients includes "nasal and oral airways of assorted pediatric and adult sizes." (Ex .J-7, Bates-stamped 103).

stamped 144-152), transcripts of the hearing before the Office of Administrative Law, the exceptions filed by the Attorney General and Dr. Bamgboye's response to the exceptions, and the arguments of counsel, the Board finds respondent deviated from the standard of care for pediatric dentists in this State by failing to exercise reasonable professional judgment in his decision to treat and in his treatment of K.P. Simply put, Dr. Bamgboye did not obtain an adequate medical history or make a reasonably thorough assessment of her ability to withstand the treatment he undertook given her condition on that date. While some of the components of treatment considered in isolation may have been supportable, for that patient, on that day, Dr. Bamgboye's actions taken cumulatively reflect a lack of judgment supporting a determination that he repeatedly deviated from the standard of care by failing to obtain an adequate history, failing to adequately assess the patient's medical condition, and failing to ensure emergency equipment was available prior to initiating treatment. Further, the record created for K.P. did not conform to the standards for record keeping for pediatric dentists for pediatric treating medically compromised patients or to the Board's rules.

In reaching its decision, the Board has rejected Judge Solomon's finding that there are no real standards of care against which Dr. Bamgboye's treatment of K.P. could be measured. The Board agrees with Dr. Brunsden's articulation of the standard of care among pediatric dentists in the State of New Jersey and that respondent deviated from that standard in several ways.

For the reasons above, the Board finds that respondent, by failing to obtain an appropriate medical history, failing to adequately assess the patient's medical condition,

and failing to ensure all emergency equipment was available, has engaged in repeated acts of negligence in violation of N.J.S.A. 45:1-21 (d).¹⁰ Further, respondent's failure to maintain his records consistent with N.J.A.C. 13:30-8.7 violates N.J.S.A. 45:1-21 (h). The legal conclusions of the ALJ in this matter are therefore modified to include these findings by the Board, and to reject the finding that there are no applicable standards of care for treatment of medically compromised pediatric patients. Finding facts in the record to support the Board's conclusion that respondent has violated the statutes and regulations governing the practice of dentistry, the Board rejects the Initial Decision dismissing the matter.

MITIGATION

Having found a basis for discipline, the Board conducted a mitigation hearing on September 1, 2010, to determine an appropriate sanction. The Board entertained arguments of counsel regarding the sanction to be imposed, and received letters submitted by respondent in support of his character and competence. Dr. Bamgboye testified. He acknowledged that he could have done things differently, but defended his decision to treat K.P. that day, stating that his "professional judgments for this patient were honest, carefully thought out and professional." Dr. Bamgboye, stating that he was not negligent, continued: "An unfortunate single incident should not define one's career." Upon questioning by Board members, Dr. Bamgboye noted that the dental practice has

¹⁰ While the Attorney General did not take exception to Judge Solomon's finding that respondent's conduct did not constitute gross malpractice or gross neglect, the Board notes that the record may well have supported such a finding with regard to the totality of respondent's actions.

made changes to the emergency protocols and equipment, including practice drills so staff is familiar with the location of emergency equipment in the office.

The Board accepts that Dr. Bamgboye did not set out to treat K.P. in anything other than an appropriate manner. But his assessment of K.P.'s medical condition and, therefore her ability to withstand treatment, did not conform to the standard of care.

The Board has viewed respondent's decision to treat K.P. using information available to Dr. Bamgboye on February 24, 2004: that is, treatment of a severely medically compromised child with a restricted airway due to congestion and a nasogastric tube, in a papoose, with a rubber dam, and strained respiration from screaming and crying during the treatment. Respondent was, at best, casual in taking K.P.'s medical history. In the presence of conflicting information, he did not press K.P.'s mother further, nor did he seek a medical consult. K.P. was a fragile patient, treatment of whom could have easily lead, and did lead, to significant complications: respiratory and cardiac arrest. While a dentist must exercise his professional judgment in making the decision to treat, that judgment must be reasonably exercised. It was not.

APPLICATION FOR COSTS AND ATTORNEY'S FEES

As to the application for costs and attorney's fees, counsel for respondent orally objected to the application at the mitigation hearing but, despite an opportunity to submit written objections to the application, did not do so. The Board has reviewed the submission of the Attorney General, including the October 5, 2010, letter from the prosecuting deputy and finds that the fees and costs sought are reasonable. This case involved prosecution of an administrative complaint that alleged serious and substantial

deviations from the standard of care for pediatric dentists in this State. As noted by the deputy attorney general, the fees requested are those that accrued between July 2008 and June 30, 2010. That time period does not reflect all fees incurred in the prosecution of this matter, for example, attorney's fees related to the preparation of the complaint and initial discovery, nor does it include the deputy's time preparing for and appearing at the July 21, 2010 and September 1, 2010, hearings. Those fees will necessarily be absorbed by the Board's licensees through license fees.

Although given an opportunity to submit papers on the issue of costs and fees in the Attorney General's application, respondent did not do so. Other than his counsel's statement on the record on September 1, 2010, that he had not had an adequate opportunity to review the submission and that the fees seemed high, respondent has not objected to the amount or calculations utilized as to investigative costs, attorneys fees, expert witness fees, transcript and other costs, nor has he submitted any documents to show he is unable to pay the assessment made by the Board.

The Board has reviewed the costs sought in this matter and find the application sufficiently detailed and the amount reasonable given the complexity of the investigation and prosecution of this matter. In its submission seeking investigative costs, the State has submitted certifications of supervising investigator Jean Murphy, as well as Daily Activity Reports which identify the precise activities performed, the amount of time spent in each activity, and the hourly rate charged. The Daily Activity Reports and certifications document costs totaling \$11,438.87.

The Board finds the portion of the application for investigative costs supported by

signed and detailed contemporaneous time records to be sufficient. Those investigative time records are kept in the ordinary course of business by the Enforcement Bureau, and contain a detailed recitation of the investigative activities performed. Furthermore the overall amount of the investigative time expended between February 2004 and November 2004, is reasonable for investigative services in this matter. The Board also finds that the rates charged, (from \$103.28 to \$105.26 per hour) to be reasonable, and takes notice that investigative costs, approved many times in the past, are based on salaries, overhead and costs of state employees. Considering the important state interest to be vindicated, protection of the public, the investigative costs imposed are certainly reasonable.

Similarly, the Attorney General's certification in this matter extensively documented the attorney time in these proceedings, detailing all costs as of June 30, 2010, with attachments. The Attorney General, through the certification of Deputy Attorney General Kay Ehrenkrantz, documented a total of \$75,740 in counsel fees by DAG Ehrenkrantz and \$3,078 in counsel fees by Deputy Attorney General Bindi Merchant. The Attorney General's certification was supported by the time sheets of DAG Ehrenkrantz and included information derived from a memorandum by Nancy Kaplen, then Acting Director of the Division of Law, Department of Law and Public Safety, detailing the uniform rate of compensation for the purpose of recovery of attorney fees established in 1999 and amended in 2005, setting the hourly rate of a DAG with more than ten years of legal experience at \$175.00 per hour (DAG Ehrenkrantz) and for deputies with fewer than five years experience, \$135.00 per hour (DAG Merchant). The Board is satisfied that the

record adequately details the tasks performed and the amount of time spent on each by the Deputy Attorney General (including research, drafting, discovery, negotiations, motions, affidavits and briefs, preparation of experts and exhibits for trial, trial presentation, and post hearing submissions). The Board is satisfied the tasks performed, while time-consuming, needed to be performed and that in each instance the time spent was reasonable. Similarly, the Board finds the rate charged by the Division of Law for its attorneys has been approved in prior litigated matters and appears to be well below the community standard. See, Poritz v. Stang, 288 N.J. Super 217 (App. Div. 1996). In the absence of respondent's objections and any indication that he is unable to pay, the Board finds the costs and fees to be reasonable.

Therefore, the Board, as announced orally on October 20, 2010, will assess the following: expert witness fees - \$ 5,000; investigative costs - \$11,438.87; attorneys' fees - \$78,818; transcript fees - \$2423 , totaling \$97,679.87.

Finally, the Board recognizes that imposing a period of active suspension may cause disruption to a dentist's practice and inconvenience his patients. In order to lessen that disruption, the Board has determined that Dr. Bamgboye may begin his active suspension one month following entry of this order. This will enable him to ensure his patients are in stable condition and/or provide coverage for them in his absence.

THEREFORE, IT IS ON THIS 15th DAY OF DECEMBER, 2010,

ORDERED THAT:

1. Respondent's license to practice dentistry shall be suspended effective on January 15, 2011, for a period of two years, three months of which shall be

served as a period of active suspension, the remainder of which shall be stayed and served as a period of probation. Respondent shall comply with the Directives Applicable to Board Licensees Who is Suspended or revoked or Whose Surrender of Licensure Has Been Accepted by the Board.

2 Respondent is assessed civil penalties, pursuant to N.J.S.A. 45:1-22 in the amount of \$10,000 for conduct with that violated N.J.S.A. 45:1-21(d) and (h). Payment of the civil penalties of \$10,000 shall be submitted by certified check or money order made payable to the State of New Jersey and shall be sent to Jonathan Eisenmenger, Executive Director, P.O. Box 45005, 124 Halsey Street, Sixth Floor, Newark, New Jersey 07101 no later than thirty days from the entry of this Final Order. Subsequent violations will subject respondent to enhanced penalties pursuant to N.J.S.A. 45:1-25.

3. Respondent is assessed the costs of the investigation to the State in this matter in the amount of \$18,861.87 and attorney's fees in the amount of \$ 78,818. Payment for the costs and attorney's fees shall be submitted by certified check or money order made payable to the State of New Jersey and submitted to the Board. In payment of the \$97,679.87, respondent, at his option, shall pay the full amount within sixty days of the entry of this order or shall make twenty-three monthly payments of \$4,070 and one payment of \$4,069.87. The first payment shall be due by February 15, 2011, and subsequent payments shall continue to be due by the fifteenth of each month until all twenty-four payments are completed. In the event that respondent does not make a timely payment, the full balance will immediately become due. Payment shall be sent to Jonathan Eisenmenger, Executive Director at the address described in paragraph

#3.

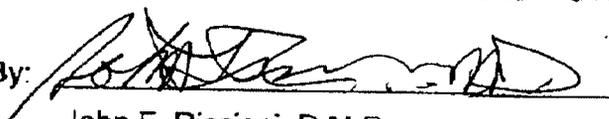
4 Failure to remit any payment as required by this Final Order will result in the filing of a certificate of debt.

5. Respondent shall successfully complete the following continuing education: seven hours in record keeping, seven hours in pediatric internal medicine, seven hours in emergency dental medicine, and seven hours in treating medically complex patient.

Proof of successful completion of the required course work shall be submitted within twelve months of the entry of this Final Order. Further, these courses, which are in addition to the regularly required continuing education hours, shall be approved by the Board in writing prior to attendance. Respondent shall complete the attached continuing education course approval. The attached form is made a part of this Final Order. A separate form shall be used for each course.

6. Failure to comply with any of the terms of this Final Order may result in further disciplinary action.

NEW JERSEY STATE BOARD OF DENTISTRY

By: 

John F. Ricciani, D.M.D.
President

**DIRECTIVES APPLICABLE TO ANY DENTISTRY BOARD LICENSEE
WHO IS SUSPENDED, REVOKED OR WHOSE SURRENDER OF LICENSURE
HAS BEEN ACCEPTED**

A practitioner whose license is suspended or revoked or whose surrender of license has been accepted by the Board, shall conduct him/herself as follows:

1. Document Return and Agency Notification

The licensee shall promptly deliver to the Board office at 124 Halsey Street, 6th floor, Newark, New Jersey 07102, the original license and current biennial registration certificate, and if authorized to prescribe drugs, the current State and Federal Controlled Dangerous Substances Registration. With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board.

2. Practice Cessation

The licensee shall cease and desist from engaging in the practice of dentistry in this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an opinion as to professional practice or its application, or representing him/herself as being eligible to practice. Although the licensee need not affirmatively advise patients or others of the revocation, suspension or surrender, the licensee must truthfully disclose his/her licensure status in response to inquiry. The disciplined licensee is also prohibited from occupying, sharing or using office space in which another licensee of this Board provides health care services. Unless otherwise ordered by the Board, the disciplined licensee may contract for, accept payment from another licensee for or rent at fair market value office premises and/or equipment. In no case may the disciplined licensee authorize, allow or condone the use of his/her provider number by the practice or any other licensee or health care provider. In situations where the licensee has been suspended for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is suspended, for the payment of salaries for office staff employed at the time of the Board action.

A licensee whose license has been revoked, suspended for one (1) year or more or permanently surrendered must remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from all prescription blanks and pads, professional listings, telephone directories, professional stationery, or billings. If the licensee's name

is utilized in a group practice title, it shall be deleted.

Prescription pads bearing the licensee's name shall be destroyed. A destruction report form shall be obtained from the Office of Drug Control (973-504-6558) and filed with that office. If no other licensee is providing services at the practice location, all medications must be removed and returned to the manufacturer (if possible), or destroyed or safeguarded. In situations where the licensee has been suspended for a period of less than one year, prescription pads and medications must be secured in a locked place for safekeeping.

3. Practice Income Prohibitions/Divestiture of Equity Interest in Professional Service Corporations

A licensee shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice. The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board action.

A licensee whose license is revoked, surrendered or suspended for a term of one (1) year or more shall be deemed to be disqualified from the practice, and shall be required to comply with the requirements to divest him/herself of all financial interest in the professional practice pursuant to Board regulations contained in N.J.A.C. 13:30-8.21. Such divestiture shall occur within 90 days following the entry of the Board Order. Upon divestiture, a licensee shall forward to the Board a copy of documentation forwarded to the New Jersey Department of Treasury, Commercial Reporting Division, demonstrating that the interest has been terminated. If the licensee is the sole shareholder in a professional service corporation, the corporation must be dissolved within 90 days of the licensee's disqualification.

4. Patient Records

If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shall ensure that during the three (3) month period following the effective date of the disciplinary order, a message will be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month for three (3) months in a newspaper of general circulation in the geographic vicinity in which the practice was conducted. At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to patient records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her patient record or asks that the record be forwarded to another health care provider, the licensee shall promptly provide the record without charge to the patient.

5. Probation/Monitoring Conditions

A disciplined practitioner whose active suspension of license has been stayed in full or in part, conditioned upon compliance with a probation or monitoring program, shall fully cooperate with the Board or its designated representatives, including the Enforcement Bureau of the Division of Consumer Affairs, in ongoing monitoring of the licensee's status and practice. Such monitoring shall be at the expense of the disciplined practitioner.

(a.) Monitoring of practice conditions may include, but is not limited to, inspection of professional premises and equipment, and inspection and copying of patient records (confidentiality of patient identity shall be protected by the Board) to verify compliance with Board Order and accepted standards of practice.

(b.) Monitoring of status conditions for an impaired practitioner may include, but is not limited to, practitioner cooperation in providing releases permitting unrestricted access to records and other information to the extent permitted by law from any treatment facility, other treating practitioner, support group or other individual or facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained by the rehabilitation program for impaired practitioners. If bodily substance monitoring has been ordered, the practitioner shall fully cooperate by responding to a demand for breath, blood, urine or other sample in a timely manner and by providing the designated sample.

6. Reports of Reimbursement

A disciplined practitioner shall promptly report to the Board his/her compliance with each directive requiring monies to be reimbursed to patients to other parties or third party payors or to any Court.

7. Report of Changes of Address

A disciplined practitioner shall notify the Board office in writing within ten (10) days of change of address.

NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Dentistry are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record thereof, including the transcript and documents marked in evidence, are available for public inspection upon request.

Pursuant to Public Law 101-191, the Health Insurance Portability and Accountability Act, the Board is obligated to report to the Healthcare Integrity and Protection Data Bank any adverse action relating to a dentist:

- (1) Which revokes or suspends (or otherwise restricts) a license; or
- (2) Which censures, reprimands or places on probation, or restricts the right to apply or renew a license; or
- (3) Under which a license is surrendered.

In accordance with an agreement with the American Association of Dental Examiners, a report of all disciplinary orders is provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order may appear on the public agenda for the monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board. In addition, the same description may appear on the Internet Website of the Division of Consumer Affairs.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.

New Jersey State Board of Dentistry
Application for Course Approval
(Please Type or Print Legibly)



124 Halsey Street . 6th Floor . Newark, NJ . 07101
phone: 973.504.6405
fax: 973.273.8075

The Board cannot assure approval for courses provided. Applications must be submitted at least 30 days prior to the course date.

A separate form is to be used for each course. A copy will be returned to you after approval or denial by the Board.

Dentist name: _____

Address: _____

Telephone #: _____

The following course is designed to fulfill a portion (or all) of _____ hours required in the area of _____

Number of credit hours requested for this particular course: _____

Course Title: _____

Sponsor: _____

Sponsor Phone Number: _____

Date(s) you will be attending course: _____

Time course begins and ends: _____

Please attach a course brochure. (Required)

For Board use only

Date: _____ Reviewed by: _____

Approved

Denied

Reason for denial: _____
