

THE STATE OF SOUTH CAROLINA
In The Supreme Court

2012-212365

APPEAL FROM THE SOUTH CAROLINA
Administrative Law Court

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JUN 22 2012

HONORABLE CAROLYN MATTHEWS

S.C. Supreme Court

Docket No. 06-ALJ-11-0562-AP (Case No. 04-45)
Docket No. 06-ALJ-11-0563-AP (Case No. 03-104)

Opinion No. 2012-UP-234 (04/18/12)

Anonymous No. 1, R.D.H., and Anonymous No. 2, R.D.H.
Petitioners,

v.

South Carolina Department of Labor, Licensing and Regulation
and South Carolina Board of Dentistry,
Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM ADMINISTRATIVE LAW COURT

The Honorable Carolyn C. Matthews, Administrative Law Judge

Case Nos. 06-ALJ-11-0562-AP and 06-ALJ-11-0563-AP

Anonymous No. 1, R.D.H., and
Anonymous No. 2, R.D.H.,

Appellants,

v.

South Carolina Department of Labor,
Licensing and Regulation, State Board
of Dentistry,

Respondents.

RECORD ON APPEAL

VOLUME I

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**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Anonymous No. 1, R.D.H., and
Anonymous No. 2, R.D.H.,

Appellants,

v.

South Carolina Department of Labor,
Licensing and Regulation, State Board
of Dentistry,

Respondent.

) Docket No. 06-ALJ-11-0562-AP

) Docket No. 06-ALJ-11-0563-AP

ORDER

The Honorable Carolyn C. Matthews
October 25, 2007

APPEARANCES: Desa Ballard, Esquire
For the Appellants

Kenneth P. Woodington, Esquire
For the Respondent

PROCEDURAL HISTORY

This matter involves two cases, which were initiated by the Board of Dentistry in October of 2004. The Board alleged in each case that the Appellants, who are licensed dental hygienists, placed sealants over obviously decayed teeth of school age children. The hygienists denied those allegations, and also alleged that their actions were within the standard of care for their industry.

Prior to the hearing, the hygienists moved for production of all complaints filed against them. This request was denied by a letter from H. Rion Alvey, Administrator of the Board of Dentistry, dated October 12, 2005. The hygienists then filed an appeal from that letter¹ with this Court. Judge Kittrell heard oral arguments on November 18, 2005, and dismissed the appeal as interlocutory by Order dated November 22, 2005.

This matter was heard by a panel of the Board on December 1 and 2, 2005. (The panel consisted of five members, none of whom were members of the Board.) By agreement of the parties and the panel, the expert testimony presented by both sides was applied in both cases. After hearing

¹ The hygienists agreed that the letter of Alvey constituted an Order of the Board.

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evidence, the panel issued written reports and recommendations for the hygienists on February 6, 2006. In the cases of Hygienists 1 and 2, the panel found violations of the standard of care. The panel recommended that Hygienist 2 be given a public reprimand and a fine of \$500, and that Hygienist 1 be given a public reprimand, but not fined.

At the final order hearing, which was held before the Board on April 28, 2006, counsel for LLR requested that the Board follow the panel's recommendation as to both cases. The only exception was LLR's request that the recommended sanctions be made public and anonymous. This request was based on the fact that these hygienists were the first ones in the public school dental program to face charges of substandard care with respect to the placement of sealants over decayed teeth. The Board accepted the recommendation of an anonymous public reprimand of Hygienists 1 and 2, but did not accept the panel recommendation of a fine in the case of Hygienist 2.

At the Final Order Hearing, the hygienists moved to recuse the Board members. While two Board members did recuse themselves, the remainder declined to do so. The hygienists also renewed their motion to be supplied with copies of the initial complaints. That motion was also denied. Final Orders in the cases of Hygienist 1 and 2 were issued on May 8, 2006. This is an appeal from those orders. This matter was heard by me on January 31, 2007, following full briefing by the parties.

STATEMENT OF THE CASE

This matter is before me pursuant to S.C. Code Ann. 40-15-200 (2001) and 1-23-600(D) (Supp. 2006). The Hygienists appeal their respective Final Orders issued by the South Carolina Department of Labor, Licensing and Regulation, State Board of Medical Examiners. In those Orders, the Board reprimanded both hygienists, holding that they failed to meet the standard of care in the practice of dental hygiene by placing sealants over obvious decay on several teeth in school-based settings.

On appeal to this Court, Appellants contend that the Board's orders were erroneous because the Board failed to recognize the existence of an independent standard of care for dental hygienists working in a public healthcare school setting. Furthermore, Appellants contend that the Board's sanctions were erroneous in the absence of harm or risk of harm to the patients, which they argue exceeds permissible state authority under the police power in violation of Appellants' rights. Upon consideration of the Record on Appeal, all briefs and oral arguments, I

find that the Board's Final Orders publicly but anonymously reprimanding Appellants must be affirmed.

STANDARD OF REVIEW

This court's review of a final decision in a contested case decided by a professional or occupational licensing board within the South Carolina Department of Labor, Licensing and Regulation is governed by the provisions of S.C. Code Ann. § 1-23-380(A) (2006). S.C. Code Ann. § 1-23-380(B) (2006); see also S.C. Code Ann. § 1-23-600(D) (Supp. 2006). Under the standard of review laid out in Section 1-23-380, this court shall not substitute its judgment for that of the [Board] as to the weight of the evidence on questions of fact. S.C. Code Ann. § 1-23-380(A)(6) (2006). However, this court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

- (a) in violation of constitutional or statutory provisions;
 - (b) in excess of the statutory authority of the [Board];
 - (c) made upon unlawful procedure;
 - (d) affected by other error of law;
 - (e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
 - (f) arbitrary and capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.
- Id.; see also Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981).

"Substantial evidence," as referenced in Section 1-23-380(A)(6)(e), is relevant evidence that, considering the record as a whole, a reasonable mind would accept to support the Board's decision. e.g., Jennings v. Chambers Development Co., 335 S.C. 249, 516 S.E.2d 453 (Ct. App. 1999). The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence. Id. Where there is a conflict in the evidence, the administrative agency's findings of fact are conclusive. Id. This court cannot substitute its judgment for that of the Board upon a question as to which there is room for a difference of intelligent opinion. E.g., Chemical Leamen Tank Lines v. S.C. Pub. Service Comm'n, 258 S.C. 518, 189 S.E.2d 296 (1972). While a decision of an administrative agency will normally be upheld, the findings may not be based upon surmise, conjecture, or speculation, but must be

founded on evidence of sufficient substance to afford a reasonable basis for it. Mullinax v. Winn-Dixie Stores, Inc., 318 S.C. 431, 443, 458 S.E.2d 76, 83 (Ct. App. 1995).

DISCUSSION

1. The Board's Finding that Both Appellants Placed Sealants Over Obvious Decay is Supported by Substantial Evidence.

a. Hygienist 1

On April 7, 2003, Hygienist 1 placed sealants over her 14 year old patients' (M.A.) permanent molars.² The issue is whether Hygienist 1 placed seals improperly over "obvious decay" on teeth nos. 3, 15, 31 and 19 of M.A. The Hygienist contends that the Respondent failed to introduce sufficient evidence to identify which of the teeth were improperly sealed. As discussed below, I find that the Board's decision was supported by the greater weight of the evidence.

About a month after the Hygienist sealed the teeth, on May 8, 2003, M.A. was seen for the first time by a dentist, Dr. Steven Chadwick. Dr. Chadwick's hygienist took intra-oral photographs of teeth nos. 2, 3, 14, 15, 18, 19, and 31. Each photograph was numbered to correspond with the number of the tooth photographed, and the number is visible in the lower left corner of each photograph. These photographs, which were introduced at the hearing, clearly identify the teeth that were sealed by the Appellant.

Further, there is evidence that the teeth were obviously decayed when the Appellant sealed them. Dr. Chadwick testified that decay was visually apparent on the teeth nos. 3, 14, 15, 31, and 19 even with the sealants in place. A typical finding by Dr. Chadwick is as follows:

A. A lot of it is just eyes, okay? . . . We just looked at these and why did they seal these teeth. That's sort of where we were coming from. The best example to me is the one labeled 31. I mean, that tooth, you can see right through the enamel and you can see the dentin and the dark.

* * *

That's gross decay.

Q. Okay. How about 19?

² The hygienist's chart indicates that sealants were applied to teeth 2, 3, 14, 15, 18, 19, 30 and 31.

- A. It looks, it looks very similar. It's obviously . . . you know, you can just look even not knowing anything about dentistry, it's black. It's not supposed to be black.

As Dr. Chadwick summarized his conclusions, "throughout all of these there was gross caries."³

Dr. Sneed, a professor of dentistry at MUSC, also reviewed the photographs of this patient's teeth and concluded that there was obvious decay, visible even through the sealants, on teeth nos. 31, 18, 15, 23, and perhaps 19. On tooth no. 31, for example, he noted that:

looking through the partially optically opaque sealants, you can see a halo of darkness underneath the sealant, extensive halo, which to me is indicative of and diagnostic of a pretty large amount of decay in that tooth.

It is apparent from the testimony of both doctors as well as the introduction of photographs of the teeth, that the Board based its decision upon the greater weight of the evidence. While Hygienist 1 claims that the testimony was not specific enough as to the teeth which were improperly sealed, the testimony and photographs, as previously summarized, very specifically identified the sealed teeth that were visibly decayed. Further, the Board's Order refers to the specific teeth that the Board found to have been improperly sealed, i.e., nos. 3, 15, 31 and 19.

The burden is on Appellant to show convincingly that the Board's Final Order is without evidentiary support or is arbitrary or capricious as a matter of law. See Hamm v. Am. Tel. & Tel. Co., 315 S.C. 119, 432 S.E.2d 454 (1993); Hamm v. Pub. Serv. Comm'n of S.C., 310 S.C. 13, 425 S.E.2d 28 (1992). Because the Appellant has not met this burden, the Appellant's challenge to the Board's findings in the case of Hygienist 1 is affirmed.

b. Hygienist 2

The Board found as a fact that Hygienist 2 "placed sealant over obvious decay on several teeth, nos. 3, 14, 19 and 30" of a patient (Q.G.). As stated below, this finding is supported by the substantial evidence in the record.

Q.G. was approximately 12 years old at the time that these events occurred in 2003. He was a patient of Dr. Benjamin Adams, a dentist in Greenville. Dr. Adams first saw this patient in February and March 2003, at which time he diagnosed decay in tooth no. 30. As a result, Dr. Adams

³ Dr. Chadwick eventually removed the sealants and filled these and other decayed teeth.

did an occlusal composite restoration on that tooth on March 4, 2003. When the patient returned to Dr. Adams on September 2, 2003, the doctor noted that there was "rampant decay" in the patient's mouth. His chart shows that he planned to do restorations, i.e., fillings, on eleven different teeth, including nos. 3, 14, 19 and 30. He also planned to seal several other teeth that were decay-free at the time.

On September 18, 2003, the patient was seen by Hygienist 2 in connection with the public health dentistry program at his school. Hygienist 2 placed sealants over teeth nos. 3, 14, 19, and 30, all of which had been diagnosed by Dr. Adams sixteen days earlier as having decay and in need of restoration.

The testimonial evidence clearly supports the Board's finding that the teeth were obviously decayed when the Hygienist placed sealants over the teeth. At the hearing, Dr. Adams was asked about the level of decay present on the four sealed teeth, i.e., teeth nos. 3, 14, 19 and 30 prior to their having been sealed. He testified as follows:

Q. Okay. Do you recall from memory what the level of decay was on those ones that you just called out? And I can really just limit it to the . . . because the only ones that were [subsequently] sealed, I think, were 3, 14, 19 and 30, I believe.

A. Well, clinically speaking, you don't know the depth of it, but using my explorer and visualization, I immediately diagnosed all those teeth [i.e., 3, 14, 19 and 30] as having decay. Using my explorer, my sharp explorer with a light touch, I got a stick, as Dr. Sneed said, just like leather-like, put it in leather and it pulls back and you get a little stick, on all those. Also visualizing, especially number 3, number 3's the one that I definitely recall seeing a dark halo on the occlusal surface from the decay present.

(Emphasis added). Dr. Adams further testified as follows:

Q. Would you characterize the decay that you observed on 9/2/03, how would you characterize that decay in terms of frank or incipient or somewhere in between?

A. It was frank. I would consider it frank because just with my naked eyes I could see a halo, an obvious halo, caused by decay on his virgin teeth. There was no question in my mind.

Dr. Adams also agreed that the decay he observed a few weeks before the sealants were placed "should . . . have been apparent to the hygienist who applied the sealants." He based his opinion on the presence of an obvious halo of decay on the patient's teeth.

Photographic evidence also supports the dentist's findings. On October 7, 2003, several weeks after the sealants were placed by Hygienist 2, Dr. Adams took a color intra-oral photograph of the four sealed teeth. During that October 7 visit, Dr. Adams only filled one of the four molars, tooth no. 3. On that tooth, he removed the sealant and performed a fissurotomy.⁴ He took another intra-oral photograph of just tooth no. 3 after the fissurotomy, and then one more photograph of the same tooth following further caries excavation. The photo after the fissurotomy and prior to the excavation confirmed Dr. Adams' previous diagnosis of frank decay.⁵

The often-repeated standard of review in APA cases is that:

The possibility of drawing two inconsistent conclusions from the evidence does not prevent an Administrative Agency's finding from being supported by substantial evidence. Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995). Rather, the appellate court need only find, considering the record as a whole, evidence that would allow reasonable minds to reach the conclusion that the administrative agency reached. Id.

Bursey v. South Carolina Dept. of Health and Environmental Control, 369 S.C. 176, 631 S.E.2d 899, 906 (2006). Dr. Adams' conclusion about frank decay, rendered particularly credible by having been reached even before the hygienist saw the patient, is clearly "evidence that would allow reasonable minds to reach the conclusion that the administrative agency reached."

Appellant argues that Dr. Adams' diagnosis depended on a physical examination of the teeth using his explorer which is outside the scope of her practice.⁶ However, both the testimony of Hygienist 1 and Katherine Way, a hygienist employed by Dr. Chadwick, supports the position that an explorer is a common tool that is used by Hygienist.⁷ Because the testimonial as well as

⁴ A fissurotomy is the removal of enamel in the grooves of teeth to gain access to decay.

⁵ Dr. Adams restored tooth no. 3, but did not do any work on the other sealed molars. The patient did not return to Dr. Adams' office after the October 7, 2003 visit.

⁶ The remainder of the Appellant's arguments pertains only to tooth no. 3, although both the testimony and the Order were to the effect that gross decay was present not only on tooth no. 3, but also on nos. 3, 14, 19 and 30. As a result, most of the Board's findings of fact are not actually challenged by this Appellant.

⁷ Hygienist 2 also argues that the opinion of Dr. Adams about the value of sealants was different from that of Appellants' expert, but that argument, even if true, does not relate to Dr. Adams' visual diagnosis of decay.

photographic evidence supports the Board's finding that the Hygienist placed sealants over gross decay, the Order of the Board is affirmed.⁸

2. **The Standard of Care for Dental Hygienists is that Sealants should Not Be Placed Over Frankly or Obviously Decayed Teeth, Regardless of the Setting in Which they Practice,**

Appellants contend that they did not violate the standard of care in their industry because the standard in the setting in which they practice -- i.e., the public school setting -- is less stringent. This contention is erroneous because there are minimal requirements of competence and professional standards that must be observed in any setting where a hygienist practices.

The standard of care in the practice of dentistry is not set forth in statutory law, but is sufficiently defined by case law. In Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985), the Court established the two prong standard that must be satisfied by a plaintiff in a medical malpractice suit. This two-prong standard is similarly applied in this case when reviewing the Board's decision, when the inquiry is whether there is a departure from the established medical standard of care. Moreover, in setting forth such a standard, our Supreme Court has held that courts will "defer to the collective wisdom of a profession, such as physicians, dentists, ophthalmologists, accountants and any other profession which furnishes skilled services for compensation." See Kemmerlin v. Wingate, 274 S.C. 62, 261 S.E.2d 50 (1981). Therefore, for the Board's decision to be upheld on appeal, the substantial evidence in the record must indicate that the Board (1) presented evidence of the generally recognized practices and procedures which would be exercised by a competent hygienist under the same or similar circumstances, and (2) presented evidence that the hygienist departed from the recognized and generally accepted standards, practices and procedures in the manner alleged by the State. See Cox, 286 S.C. at 411.

⁸ The issue about placement of sealants over gross decay being a violation of the standard of care is discussed below.

Dr. William D. Sneed, professor and Chairman of the Department of General Dentistry at MUSC, testified with respect to the standard of care where sealants are placed by dental hygienists.

His testimony can be summarized as follows:

1. There is only one standard of care in South Carolina with respect to the placement of sealants by dental hygienists over frank cavitation. That standard of care applies in both public health settings and in private dental offices.
2. That standard of care is that sealants should not be placed over decay which is frank, i.e., involving gross carious lesions.
3. A dental hygienist should be able to detect frank cavitation on a molar. The tools available to hygienists for making this determination include visual examination with the naked eye and the use of explorer tools.

Dr. Sneed further testified that the reasons for not placing sealants over frank decay are that

... you'd give a false sense of security to the patient and to the parent. ... [I]t would be very difficult to achieve a hermetic seal, a very good seal.

* * *

And if it breaks, if that seal breaks and you've left decay, it is rampant. It becomes ... in a matter of months you could have an exposure, a toothache, a root canal. So my concern with sealing a frankly cavitated lesion would be just that. You might get a sealant right now possibly, you may very well, but is it going to stay there. We see it all the time, a portion comes loose, now it leaks; the patient has a false sense of security, it's an opaque sealant, mama sees something white on there, it looks fine, and it may progress extremely rapidly. The same thing happens with a cracked filling. If you have a cracked amalgam and the amalgam is loose but won't fall out, that's the worst possible scenario, because now it's leaking, saliva, bacteria, sugar, so forth are getting up under there.

In contrast to this testimony of Dr. Sneed, the expert retained by the Appellants, Dr. Simonsen, took the position that "it is okay to place sealant under any circumstances." His testimony, however, was given less credence by the Board because evidence was introduced that the expert told Dr. Sneed in an e-mail exchange over a year before the hearing that caries could progress under an inadequately placed sealant, thereby leading both to increased decay and a false sense of security on the part of the patient and the parent. While Dr. Simonsen attempted to qualify these

remarks at the hearing, his e-mail, which was presumably written before he was retained by the Appellants to testify in this case, made it clear that he and Dr. Sneed are in agreement that it is inappropriate to place sealants over frank cavitation.⁹ Moreover, it appears that Dr. Simonsen based even his revised view on an unduly optimistic scenario:

... I can't imagine that a sealant would be placed over a carious lesion without the parent or the child being informed that there is caries present and that requires attention of the dentist.

The Board credited the opinion of Dr. Sneed (and impliedly also credited the original opinion of Dr. Simonsen) by concluding that "there is a deviation from the standard of care, regardless of setting (including the public health setting), when sealant is placed over clinically obvious decay."

Further, Dr. Sneed's opinion is consistent with the DHEC "Guidelines for SC School-Based Dental Prevention Programs." Those Guidelines were incorporated into the contract between DHEC and the hygienists' employer. On the last page of the Guidelines, there is a decision tree. It indicates that in the public health setting, sealants should be placed over "questionable" teeth, that is, those for which it is not certain that surface (enamel) decay is present, and also over teeth which have enamel or surface decay. In instances where there is decay in the dentin, that is, below the surface (which existed in the present two cases), the Guidelines make no mention of sealing the tooth, instead noting that the tooth should be restored, i.e., filled. In other words, the "double standard" that Appellants argue for is not even found in the terms of their agreement with DHEC for just this public health setting.¹⁰

Also contrary to the position of Appellants' counsel is the testimony of Hygienist 2, who testified that sealants should be placed only on "all kids that don't have gross decay." She also agreed that it was part of her responsibility to be able to spot gross decay. The other hygienist,

⁹ Appellants cite several studies in support of the position they advocate. However, Dr. Sneed testified that those studies involved the placement of sealants over caries in a manner that effectively converted them into restorations rather than sealants. He also testified that that painstaking procedure was not one which could be performed by hygienists.

¹⁰ Moreover, placing sealants over gross decay is more damaging to the dental health of children who do not make follow-up visits to the dentist, because, as Dr. Sneed testified, the false sense of security remains present, while the teeth continue to decay at an accelerated rate. In the other situation, that is, the child who does go to the dentist, if a tooth is improperly sealed with the sealant covering gross decay, the situation will soon be remedied by a visit to the dentist, who will remove the sealant and fill the tooth. This, indeed, is what happened for at least some of the teeth of the children who were the patients in the present two cases.

Hygienist 1, likewise testified that she does not seal gross decay. Hygienist 1 also agreed that part of her training was to enable her to recognize tooth decay.

After reviewing the testimony of the Hygienist and the experts, I find that the Respondents presented substantial evidence to show that the Hygienist deviated from the generally recognized practices and procedures which would be exercised by competent hygienists under the same or similar circumstances. "It is generally recognized that the trier of fact, who has the opportunity to observe the witnesses and listen to their testimony in person, is in the best position to determine issues of witness credibility." Dixon v. Dixon, 336 S.C. 260, 263, 519 S.E.2d 357, 358 (Ct. App. 1999). My finding, which is consistent with that of the Board's, is that Dr. Sneed's testimony was more than merely "substantial"; it was the more credible testimony offered because it was internally consistent and consistent with the testimony of the hygienists concerning their standard of care. Therefore, the Board's finding that the Hygienist deviated from the standard of care in the industry is affirmed.

Compliance with this minimal standard of practice should not "chill" the public health dental hygiene program. The Board was careful to note that the hygienists were not required to find decay when decay was not apparent to them using the tools they had available to them. Thus, the Board concluded that "In the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal." Moreover, in these first instances of violation of the standard of care in this area, the Board issued the most minimal sanctions it could have issued while still making the standard of care publicly known to the community of dental professionals.

3. Proof of Actual Harm of a Specific Nature is Not an Element of a Professional Disciplinary Proceeding.

Appellants argue that the Respondent exceeded its authority under the state's police power and violated Appellants' rights by finding that they committed professional misconduct in the absence of harm to the patients.

It is true that the court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are in violation of constitutional or statutory provisions or in excess of the statutory

authority of the Board. S.C. Code Ann. § 1-23-380(A)(6) (2006). However, this is not one of those instances because the Appellants fail to take into account the difference between a professional disciplinary proceeding and a professional malpractice claim.

In a malpractice case, the patient is seeking to recover damages because of harm actually done to him by the actions of the professional. In that context, the plaintiff can recover damages only if he actually suffers harm.

The purpose of professional disciplinary proceedings in cases of this kind is to protect the public from substandard professional care. It is therefore clear that professional misconduct is not excused simply because for some reason the patient did not suffer harm. See In Re Matter of H. Jackson Gregory, 332 S.C. 13, 503 S.E.2d 735 (1998) (Finding that an attorney violated Rule 1.1 of the Professional Rules of Conduct for failing to provide competent representation even though no harm to the parties resulted from the attorney's inattention to detail in keeping his client's finances).

In the present two cases, no harm resulted to some of the patients' teeth for the simple reason that the patients visited dentists not long after the sealants were placed. However, as discussed above, this absence of harm has no bearing on the Board's ability to discipline the hygienists. Therefore, I find that the Board acted within its authority when it found that the Appellant committed professional misconduct.

4. The Board's Failure to Disclose the Initial Complaints In these Cases.

With respect to their request to see the original complaints filed against them, Appellants have argued that this case is identical to the Medical Board case of South Carolina Department of Labor, Licensing and Regulation v. Girgis, 332 S.C. 162, 503 S.E.2d 490 (Ct. App. 1998). The Board argues, however, and the Court agrees, that the statutes requiring that information in Dental Board cases be kept confidential are substantially different from the Medical Board statute applied in Girgis. In addition, the General Assembly has in recent years enacted a number of provisions indicating that Girgis required the agencies to disclose more than the legislature ever intended.

The Medical Board statute in effect when Girgis was decided, then-Section 40-47-212, contained the language quoted below:

Every communication . . . made by . . . any person . . . to the [Medical] Board . . . by way of complaint or testimony . . . shall be privileged; and no action or proceeding, civil or criminal, shall lie against such person . . . except upon proof that such communication was made with malice.

No part of this article shall be construed as prohibiting the respondent or his legal counsel from exercising the respondent's constitutional right of due process under the law, nor to prohibit the respondent from normal access to the charges and evidence filed against him as a part of due process under the law.

(Emphasis added.)

The statutes pertaining to the Board of Dentistry contain similar language to the first paragraph quoted above. Specifically, § 40-15-180(4) provides that

(4) Every communication . . . made by or on behalf of any complainant . . . to the board . . . by way of complaint or testimony, shall be privileged, and no action or proceeding, civil or criminal, shall lie against any such person. . . by reason thereof.

In addition to this provision, however, there are two provisions in the Dental Practice Act that do not appear in the former Medical Practice Act. Section 40-15-180(3) provides:

(3) All investigations and proceedings undertaken under the provisions of this chapter shall be confidential.

(Emphasis added.) In addition, § 40-15- 215 provides that

[a]ll information, investigations, and proceedings concerning the circumstances underlying an action by the holder of the license or certificate is privileged and confidential.

(Emphases added.)

Finally, the Dental Practice Act does not contain the language, found in the former Medical Practice Act, that its provisions do not "prohibit the respondent from normal access to the charges and evidence filed against him as a part of due process under the law." Instead, the Dental Practice Act provides that "The accused shall have the right to be confronted with and to cross-examine the witnesses against him and shall have the right to counsel." § 40-15-180(1).

While the language pertaining to "access to the charges and evidence filed against the respondent as part of due process under the law" is absent from the Dental Practice Act, it is

nevertheless present in § 40-1-190(B), the overall governing statute for LLR boards. Section 40-1-190(B) provides that

Nothing in this article may be construed as prohibiting the respondent or the respondent's legal counsel from exercising the respondent's constitutional right of due process under the law or as prohibiting the respondent from normal access to the charges and evidence filed against the respondent as part of due process under the law.¹¹

The presence of this language in the general governing statute does not, however, serve to vitiate the more specific language in the Dental Practice Act. It is, of course, well settled that

Where there is one statute addressing an issue in general terms and another statute dealing with the identical issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect.

Capco of Summerville, Inc. v. J.H. Gayle Const. Co., Inc., 368 S.C. 137, 142, 628 S.E.2d 38, 41 (2006).¹² The Dental Practice Act contains a more specific, more limited, provision regarding access to information. Instead of providing for "access to the charges and evidence filed against the respondent as part of due process under the law," as set forth in the general provisions of § 40-1-190(B), the Dental Practice Act limits such "access" by providing only that "[t]he accused shall have the right to be confronted with and to cross-examine the witnesses against him. . . ." This language, by its plain terms, requires only that a licensing board must permit cross examination of witnesses who testify before the Board against the respondent licensee.¹³ This right was accorded in this case.¹⁴

¹¹ The previous paragraph, § 40-1-190(A), contains the language about "privileged" communications, but does not use the word "confidential."

¹² Chapter I of Title 40 was enacted in 1996 by Act No. 453 of that year. This makes it a later statute than the cited provisions of the Dental Practice Act, which were last enacted in 1993, but as a general rule, a more specific statute is generally held to prevail over a general statute even if the general statute was the last enacted of the two. Norman J. Singer, Sutherland Statutes and Statutory Construction § 51.5 (6th ed. 2005)

¹³ The Board has argued that Girgis was wrongly decided, since the matters in the initial complaint are not part of "the charges and evidence filed against [the licensee]," and that only the Formal Complaint and the evidence presented to the Board meets that description. The Court does not need to reach this issue since that language is not part of the Dental Practice Act.

¹⁴ While Appellants refer to constitutional rights in their arguments on this point, it is clear that what they actually seek is discovery. However, there is no constitutional right to discovery even in criminal cases, see, e.g., Weatherford v. Bursey, 429 U.S. 545, 559 (1977), much less in administrative proceedings of a non-criminal nature. See, e.g., Matter of Del Rio, 400 Mich. 665, 256 N.W.2d 727 (1977).

The Dental Practice Act also contains other specific provisions not found in either the former Medical Practice Act construed in Girgis or in the general provisions of Chapter 1 of Title 40. As noted above, § 40-15-180(3) provides:

(3) All investigations and proceedings undertaken under the provisions of this chapter shall be confidential.

(Emphasis added.) In addition, § 40-15-215 provides that

[a]ll information, investigations, and proceedings concerning the circumstances underlying an action by the holder of the license or certificate is privileged and confidential.

The term "confidential" was not to be found in the former Medical Practice Act. See former §§40-47-212, 40-47-213. Girgis, construing a statute which used only the term "privileged" and not the additional term "confidential," concluded that "the privilege referred to in the identical statute is a privilege against liability rather than an absolute privilege against disclosure of the name of the complainant." 332 S.C. at 170, 503 S.E.2d at 494. It is unlikely that the Court of Appeals would have held the initial complaint disclosable if the language requiring confidentiality had been present in the former Medical Practice Act.

Several post-Girgis developments also support this Court's holding that the General Assembly has not intended for LLR to disclose initial complaints in disciplinary cases. In 2005, the General Assembly effectively abrogated any requirement of Girgis that the initial complaint must be supplied to the licensee in Medical Board cases. Section 40-47-213(A)(2), as amended by Act No. 150 of 2005, provides that

The name of the initial complainant must be provided to the licensee who is the subject of the complaint, investigation, or proceeding unless the board, hearing officer, or panel determines there is good cause to withhold that information.

(Emphases added.) This amendment of the Medical Practice Act clearly indicates that the General Assembly has never intended for the initial complaint itself to be supplied to the licensee; indeed, the amended Medical Practice Act even allows the Medical Board to withhold the identity of the complainant if there is good cause to do so. The amendment therefore provides another reason why the Board was correct in declining to provide Appellants with the initial complaints in these cases.

Another post-Girgis development shows that there was never an intent for Chapter 1 of Title 40 to supersede the more specific provisions in the statutes pertaining to each particular licensing

board. The new Medical Practice Act begins with a provision setting forth the following rule of construction:

(A) Unless otherwise provided for in this chapter, Chapter 1, Title 40 applies to the profession or business regulated under this chapter. However, if there is a conflict between this chapter and Article 1, Chapter 1, Title 40, the provisions of this chapter control.

§ 40-47-5 (Supp. 2006). The Dental Practice Act has not received an overall revamping since the 1996 enactment of Chapter 1 of Title 40, but in the cases of boards like the Medical Board whose legislation has been reworked since 1996, the legislation starts out with this language to the effect that the legislation for the specific board controls the general provisions of Chapter 1. *See, e.g.,* § 40-3-5 (Architecture Board); § 40-33-5 (Nursing Board); § 40-22-5 (Engineering Board). The consistency with which the General Assembly inserts this provision into revisions indicates a clear intent that the general provisions were never intended to supersede the legislation pertaining to individual boards.

5. Appellants' Motion to Recuse Was Properly Denied, Because Appellants Did Not Make A Prima Facie Showing of Bias by the Board Members Who Heard this Case.

Appellants claim that persons engaged in the private practice of dentistry want to suppress the use of preventive care in school settings by hygienists because "caries-free teeth, or reduced incidence of caries, are not economically beneficial to the private practice of dentistry when providers can recover larger revenues from restorative dentistry than they can from preventative care."

In Kizer v. Dorchester County Vocational Educ. Bd. of Trustees, 287 S.C. 545, 340 S.E.2d 144 (1986), the Supreme Court of South Carolina held that school board members, and presumably other administrative tribunals,

are clothed with a presumption of honesty and integrity in the discharge of their decision-making responsibilities. [Citations omitted] In order to disqualify a hearing tribunal, actual bias rather than a mere potential for bias must be shown. [Citations omitted] Individual decision makers must not have exhibited bias as to the factual questions to be decided at hearing, and evidence of actual bias which offends due process consists of statements on the merits by those who must make factual determinations on contested fact issues where fact finding is critical. [Citations omitted] It is not

actual bias to have made statements as to policy issues related to a dispute. . . .Id at 148.

The allegations of the Appellants are several steps removed from amounting to a prima facie showing of possible bias.

First, Appellants' allegations are not statements of fact, but rather conclusory and broad assertions that members of the Board would be prejudiced towards hygienists who exercise preventative care. The Court of Appeals has held that "it is not enough for a party to allege bias; a party seeking disqualification of a judge must show some evidence of bias or prejudice." Reading v. Ball, 291 S.C. 492, 494, 354 S.E.2d 397, 398 (Ct. App. 1987). As stated by the Supreme Court of Alabama, "recusal is not required by a mere accusation of bias unsupported by substantial fact." Acromag-Viking v. Blalock, 420 So.2d 60, 61 (Ala. 1982). Appellants have shown no facts, but have only offered unsubstantiated arguments in support of their claims.

Secondly, the allegations would appear to relate to statements concerning policy issues, which were held in Kizer, *supra*, not to be proper subjects of a motion to recuse. Appellants' allegations about general policy have no relation to the issues in these cases, which as Kizer held, are "factual determinations on contested fact issues where fact finding is critical." Nor would Appellants' allegations even remotely suggest that any member of the current Dental Board might be inclined to reach predetermined conclusions about the facts of these cases.¹⁵

Finally, Appellants suggest that recusal is appropriate under the standard enunciated in Liljeberg v. Health Services Acquisition Corp., 486 U.S. 847 (1988). There, it was held that recusal is required "if a reasonable person, knowing all the circumstances, would expect that the judge would have actual knowledge [of facts that would make him susceptible to a charge of bias]." 486 U.S. at 861. However, the facts of Liljeberg are far different from those here. In that case, the district judge was a current trustee of a university that had a cognizable interest in the litigation. Such a connection to the case was sufficient, the Supreme Court held, to cause an objective observer to question the judge's impartiality. In the present case, however, there is

¹⁵ In addition, Appellants fail to note that the membership of the Dental Board in 2001, when certain actions were taken of which Appellants complain, is not the same as it is at present. Only two dentists and the one public member now on the nine-person Board were members of the Board in 2001. Those individuals are Dr. Bragdon, Dr. Bedell, and Ms. Duncan. Of those three, Dr. Bedell did recuse herself. She had been a witness in 2001 at an ALC hearing on the then-controversial regulation about preexaminations by dentists. Ms. Duncan is the "public member" of the Board. She is not a dentist, and therefore is not even susceptible to the charges of bias that Appellants have made.

simply no connection between being a dentist and having the ability to conduct a fair hearing on the issue of whether dental sealants might have been improperly placed in a few apparently isolated cases.

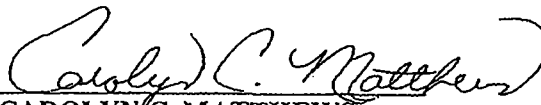
As previously indicated, one Board member, Dr. Millwood, recused himself at the outset of the hearing.¹⁶ Although Appellants had made no particular showing indicative of potential bias, the Board nevertheless did permit counsel for Appellants to conduct a voir dire of the sitting Board members. Following that voir dire, each remaining member of the Board, except Dr. Bedell as already indicated, declined to recuse himself or herself. This was not error, in light of the absence of a showing of bias by the Appellants. See State v. Hawkins, 310 S.C. 50, 425 S.E.2d 50 (1992) (holding that a judge's alleged financial interest as a taxpayer in a county being sued by the criminal defendant did not entitle the defendant to recusal of the judge from the criminal case because nothing indicated actual bias or prejudice by the judge).

Because Appellants have made no showing of what additional evidence they would desire to present, nor, more importantly, have they made any attempt to show that they were not able to present it to the Board, the Appellants Motion to Recuse was properly denied.

ORDER

For the foregoing reasons, the Court concludes that the Orders of the Board in these two cases must be, and hereby are, affirmed.

AND IT IS SO ORDERED.


CAROLYN C. MATTHEWS
Administrative Law Judge

October 25, 2007
Columbia, South Carolina

COPIES OF SERVICE
This is to certify that the undersigned has this date
served this order in the above entitled action upon all
parties in this cause by depositing a copy hereto,
in the United States mail, postage paid, or in the Interagency
Mail Service addressed to the party(ies) or their attorney(s).

This 25th day of October, 2007
by Shelly H. Zeller
Attorney at Law

¹⁶ Dr. Millwood had been a defendant in a federal case brought by the employer of the hygienists in this case. No. 3:03-3230, Health Promotion Specialists, Inc. v. South Carolina Dental Association, et al. (D.S.C.).

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
STATE BOARD OF DENTISTRY

Docket No. 06-ALJ-11-0562-AP
[In Re: Case No. 04-45]
Docket No. 06-ALJ-11-0563-AP
[In Re: Case No. 03-104]

Anonymous No. 1, R.D.H., and Anonymous No. 2, R.D.H. Appellants,

v.

South Carolina Department of Labor, Licensing and Regulation,
South Carolina Board of Dentistry, ... Respondent.

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BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:)

Anonymous, R.D.H.,)

FINAL ORDER

Case No. 03-104)

Respondent.)

This matter came before the Board of Dentistry (the Board) for hearing on April 28, 2006, as a result of the Formal Accusation and Notice of Hearing dated October 28, 2004 and October 24, 2005, which were served upon the Respondent and filed with the Board, and the report and recommendation dated February 6, 2006 of a panel which heard this matter. A quorum of the Board was present. The hearing was held pursuant to S.C. Code Ann. §§40-15-180 and 200, as amended, S.C. Code Ann. §40-1-70(6), and the provisions of the Administrative Procedures Act (the APA), S.C. Code Ann. §1-23-10, et seq. (1976), as amended. The State was represented by Kenneth P. Woodington, Esquire. The Respondent appeared with counsel, Desa A. Ballard, Esquire.

The Respondent was charged with violation of S.C. Code Ann. §40-15-190(A)(14).

FINDINGS OF FACT

Based upon the preponderance of the evidence on the whole record, the facts of the case are found to be as follows:

1. The Respondent is currently licensed as a hygienist in South Carolina, and was so licensed at all times relevant to the issues raised in this matter.

2. On September 2, 2003, the patient Q.G. was seen by Dr. Benjamin S. Adams. The child was examined and given a cleaning (a "prophy"). The dentist's hygienist noted that the child had "rampant decay." The dentist also testified that the decay was not incipient decay but was frank (manifest or evident) decay which should have been evident to the Respondent. He stated that the decay could be seen with the eyes.

3. On September 18, 2003, the Respondent, while employed by Health Promotion Specialists, saw the patient, conducted a

medical history, cleaned the teeth (a "prophy"), applied fluoride, and placed sealants over teeth #s 3, 14, 19, and 30. The Respondent coded the condition of the teeth as a code 10, meaning there is no obvious problem. The Respondent's records indicated that Dr. Adams was the child's dentist, and a prior cleaning had been performed earlier in the year.

4. On October 7, 2003, the patient returned to Dr. Adams. His record noted that sealants have been placed on teeth #s 3, 14, 19, and 30, which had previously been described as having rampant decay.

5. The Respondent's expert testified that in this case the caries was incipient and not gross. He stated that the sealants placed on the four teeth at issue were within the standard of care for a child in a public health setting.

6. Expert and other evidence given in the first of four companion cases was presented in full in the first case and preserved for application to subsequent cases. A summary of a portion of that evidence is repeated below for purposes of evaluating this case.

7. The State's expert testified as to his opinion of the standard of care regarding the placement of sealants. He stated that the placing of sealants over frank decay is not within the standard of care. He stated that hygienists should be able to detect gross decay which has reached the dentin. The use of their explorer (a probing instrument), light, color, texture, obvious breaks, and haloing are diagnostic.

8. The State's expert, Dr. William Daniel Sneed, discussed the proper use of sealants when decay is present. Sealant may be appropriate when there is small incipient decay. Use may be appropriate if decay is small and very defined in pits and fissures, and there is no indication of reaching the DEJ (dentinoenamel junction, the surface at which the enamel and the dentin of the crown of a tooth are joined). A good seal is difficult to obtain. As the area of decay becomes larger, there is the loss of good enamel to which the sealant can adhere. If done properly under these limited circumstances, the growth of decay may be inhibited. When decay spreads to the DEJ or becomes too large, it is difficult to achieve a hermetic seal. A seal must reach beyond the decay to solid enamel to adhere. If there is frank decay, sealing is not indicated and decay may spread. This view is supported in the professional literature

and among the expert's peers. There are minimal references to the placement of sealants over frank decay in the literature, and it is not the standard of care. The expert testified that if a hygienist encounters gross decay, the patient and parent should be advised to see a dentist for a restoration. Placing sealants over frank decay may give a false sense of security. If the seal breaks, since the teeth will be coated by the sealant, the decay will be difficult to see. It will not be black, but white, and the problem may be ignored. We adopt the State's expert's opinion and reasoning that the placing of sealants over frank (we will use the synonym "obvious" in an effort to provide more clarity) decay is not within the standard of care, and that the Respondent's expert's opinion (see below) regarding the placement of sealants over frank decay is not the standard of care, but represents a minority view. Further, we agree with the opinion that the placing of sealants over frank or obvious decay is not within the standard of care in the public health setting or in any other setting, as the dangers described in such inappropriate sealing are present in the public health setting as in other settings.

9. The Respondent also presented an expert, Dr. Richard J. Simonsen, to testify regarding the proper use of sealants and the standard of care. A summary of his comments follows. Sealants prevent the growth of decay by cutting off oxygen and nutrients. Sealants do not themselves cause decay, even if part of the seal is lost. He noted that in the public health setting, the patient may not receive further dental care. The assumption must be made that the likelihood of further care is small, so the decision to use sealants is different in the public health setting from the private setting. If the patient has never seen a dentist, then it is not likely that he will have further care. Sealing is appropriate in situations such as these. If there is frank decay, sealant can be used, the patient and parents are advised this will not cure the problem, and they are advised to see a dentist. It was within the standard of care to use sealants in these situations (including that of companion cases to this one). In this case there was incipient caries present, however, the Respondent did not deviate from the standard of care by placing sealants on these four teeth. The treatment was within the standard of care for a child in a public health setting. In this case, the patient did see a dentist shortly after the treatment by the Respondent. This accomplished one of the goals of a school based program, which is to have students see a dentist. The placement of sealants is not harmful. The breaking of a seal does not create

a problem. Even a partial sealant is better than none at all. If a child is not likely to return, it is beneficial to seal over lesions. If caries is properly sealed off, it may be retarded.

10. The Respondent presented testimony from a Department of Health and Environmental Control (DHEC) representative from the oral health program under whose aegis the school based program in this case operates. Materials were presented which included the "Guidelines for SC School-Based Dental Prevention Programs." The section on Dental Sealants reads: "All patients that have teeth with structural characteristics that place them at risk for decay should be considered for preventative sealants. Patients that have teeth with questionable decay should also be considered for sealants (therapeutic sealants). A third type of dental sealant, interim sealant, may be used in community and school based programs. These sealants are used to slow down the decay process in some teeth that have dentinal caries. Interim sealants are not recommended unless a dentist examines the patient and determines that the patient is unlikely to access restorative services in the near future and the size of the lesion is not too large to preclude the procedure" (emphasis added). A second paragraph continues: "According to the proceedings of the workshop on sealant guidelines, " The goal of preventing caries through widespread use of sealants will be accomplished best by providing preventive sealants to individuals at high risk and placing therapeutic sealants on carious lesions that are limited to enamel."

11. After considering all the evidence introduced in these cases, we adopt the opinion of the State's expert and find that there is a deviation from the standard of care, regardless of setting (including the public health setting), when sealant is placed over clinically obvious decay. In the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal. We find that the evidence is clear that, as to this patient, the Respondent violated the standard of care. The Respondent inappropriately sealed teeth #'s 3, 14, 19, and 30. The Respondent's treatment of the patient failed to meet the standard of care in the practice of dental hygiene, and was outside the range of acceptable dental hygiene practice in similar situations in that the Respondent placed sealant over obvious decay on several teeth, #'s 3, 14, 19, and 30. The decay was described by the dentist's hygienist as rampant before the patient was seen by

the Respondent. The Respondent coded the case as having no obvious problems when clearly a dentist's intervention was needed.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this case, it is found and concluded as a matter of law that:

1. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. §40-15-190, has the authority, pursuant to S.C. Code Ann. §40-15-200, to revoke or suspend a license or registration certificate, publicly or privately reprimand a licensee, or take any other reasonable action short of revocation or suspension, such as probation or the imposition of a civil penalty of up to ten thousand dollars, or requiring the person to undertake additional professional training subject to the direction and approval of the Board, psychiatric evaluations, controlled substances restrictions, institutional practice under supervision, and any other actions considered appropriate by the Board. Upon finding that grounds for discipline exist, S.C. Code Ann. §40-1-120 provides that the Board has the authority to: issue a public reprimand; impose a fine not to exceed five hundred dollars; place a licensee on probation or restrict or suspend the individual's license for a definite or indefinite time and prescribe conditions to be met during probation, restriction, or suspension including, but not limited to, satisfactory completion of additional education, of a supervisory period, or of continuing education programs; permanently revoke a license; and impose the reasonable costs of the investigation and prosecution of a case.
2. The Respondent has violated S.C. Code Ann. §40-15-190(A)(14) in that she has failed to meet the standard of care in the practice of dental hygiene, as evidenced by her placement of sealant over obvious decay on several teeth as described above.
3. The sanction imposed is consistent with the purpose of these proceedings and has been made after weighing the public interest and the need for the continued services of qualified dental hygienists against the countervailing concern that society be protected from professional ineptitude and misconduct.

4. The sanction imposed is designed not to punish the Respondent, but to protect the welfare of the public at large.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that:

1. The Respondent be, and she hereby is reprimanded.

AND IT IS SO ORDERED.

THE BOARD OF DENTISTRY


William H. Bragdon, D.D.S.
President

May 8, 2006.

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

ANONYMOUS, R.D.H.,
License No.

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that I have this day served the within FINAL ORDER upon the person hereafter named, by depositing a copy of same in an envelope, securely wrapped in the United States Mail, Certified Mail, Return Receipt Requested, properly addressed with pre-paid postage to the said person hereafter named, at the place and address stated below, which is the last known address for the same.

Desa Ballard, Esquire
226 State St.
West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION
STATE BOARD OF DENTISTRY

BY:


H. RION ALVEY
Administrator

Columbia, South Carolina

May 16, 2006

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

Anonymous, R.D.H.,

Case No. 04-45

Respondent.

FINAL ORDER

This matter came before the Board of Dentistry (the Board) for hearing on April 28, 2006, as a result of the Formal Accusation and Notice of Hearing dated October 11 and October 24, 2005, which were served upon the Respondent and filed with the Board, and the report and recommendation dated February 6, 2006 of a panel which heard the matter. A quorum of Board members was present. The hearing was held pursuant to S.C. Code Ann. §§40-15-180 and 200, as amended, S.C. Code Ann. §40-1-70(6), and the provisions of the Administrative Procedures Act (the APA), S.C. Code Ann. §1-23-10, et seq. (1976), as amended. The State was represented by Kenneth P. Woodington, Esquire. The Respondent appeared with counsel, Desa A. Ballard, Esquire.

The Respondent was charged with violation of S.C. Code Ann. §40-15-190(A) (14).

FINDINGS OF FACT

Based upon the preponderance of the evidence on the whole record, the facts of the case are found to be as follows:

1. The Respondent is currently licensed as a hygienist in South Carolina, and was so licensed at all times relevant to the issues raised in this matter.

2. On April 11, 2003, the Respondent saw patient M. A., 14 years old, while working for Health Promotion Specialists in a school based public health setting. The Respondent's chart indicated that a medical history was taken, the teeth were cleaned (prophylaxis, or a "prophy"), fluoride was applied, and sealants were placed on teeth #s 2, 3, 14, 15, 18, 19, 30, and 31. She coded the condition of the teeth as a code 11, indicating obvious problems which require a referral to a dentist. She noted that the teeth are "stained, decay is sticky throughout." On May 20, 2003, she recorded a call from Dr.

Chadwick who treated the child after the Respondent's treatment, and she noted that she explained that the area was sticky and stained, but there were no signs of gross (unsealable) decay.

3. M.A. visited Dr. Chadwick's office on May 8, 2003 where an initial examination was made and x-rays were taken by Dr. Chadwick's hygienist who testified that gross decay could be detected visually. Dr. Chadwick placed twelve fillings that day on one side of the patient's mouth. On May 29, 2003, he placed another twelve fillings on the other side of the mouth. Photographs and x-rays were placed into evidence. Dr. Chadwick testified generally regarding the conditions he found, and specifically as to several teeth. He stated that on tooth #3 gross caries could be noted visually. When removing sealants, it was apparent to him that there was gross decay. Tooth 14 was better than the others, although the seal was not complete. Tooth 15 was partly sealed and gross decay was present down to the dentin. Tooth 31 showed gross decay into the dentin. Tooth 19 also had apparent decay. He stated that when the sealant was removed, all the teeth were grossly decayed.

4. On February 17, 2004, the Respondent saw patient T.M., a ten year old, while working for Health Promotion Specialists in a school based public health setting. The Respondent performed a history, cleaned the teeth (a "prophy"), applied fluoride, and sealed teeth #s 3, 14, 19, and 30. She noted a "slight stick greater on mesial" of # 3. She coded the teeth as a code 11, indicating obvious problems which require a referral to a dentist.

5. On February 19, 2004, the patient visited Dr. Chadwick's office, where his partner filled primary teeth and one permanent tooth, # 3. Dr. Chadwick stated that gross caries was under the sealant. The Respondent testified that she saw the decay in this case, and recommended that a dentist be seen. She did not think it was likely that the patient would have follow-up dental care. She stated that she does not routinely seal teeth in all cases, and did not seal over gross decay.

6. The State presented its expert witness, Dr. William Daniel Sneed, to testify as to the standard of care applicable to this case (and also to three companion cases). In regard to patient M.A., he noted on tooth # 31 some areas not sealed and a large amount of decay which reached the dentinoenamel junction (DEJ, the surface at which the enamel and the dentin of the crown of a tooth are joined). On tooth # 19, he noted obvious

decay which had entered the dentin. Tooth # 15, he found not to be as clear. It was not fully sealed, and decay was suspect. Tooth # 18 had a good seal but decay is again suspect. Teeth #s 23, 19, and 31 had gross decay which was at the DEJ. On Patient T.M., he stated that tooth # 3 needed operative intervention.

7. The State's expert testified as to his opinion of the standard of care regarding the placement of sealants. He stated that the placing of sealants over frank (manifest or evident) decay is not within the standard of care. He stated that hygienists should be able to detect gross decay which has reached the dentin. The use of their explorer (a probing instrument), light, color, texture, obvious breaks, and haloing are diagnostic.

8. The State's expert discussed the proper use of sealants when decay is present. Sealant may be appropriate when there is small incipient decay. Use may be appropriate if decay is small and very defined in pits and fissures, and there is no indication of reaching the DEJ. A good seal is difficult to obtain. As the area of decay becomes larger, there is the loss of good enamel to which the sealant can adhere. If done properly under these limited circumstances, the growth of decay may be inhibited. When decay spreads to the DEJ or becomes too large, it is difficult to achieve a hermetic seal. A seal must reach beyond the decay to solid enamel to adhere. If there is frank decay, sealing is not indicated and decay may spread. This view is supported in the professional literature and among the expert's peers. There are minimal references to the placement of sealants over frank decay in the literature, and it is not the standard of care. The expert testified that if a hygienist encounters gross decay, the patient and parent should be advised to see a dentist for a restoration. Placing sealants over frank decay may give a false sense of security. If the seal breaks, since the teeth will be coated by the sealant, the decay will be difficult to see. It will not be black, but white, and the problem may be ignored. We adopt the State's expert's opinion and reasoning that the placing of sealants over frank (we will use the synonym "obvious" in an effort to provide more clarity) decay is not within the standard of care, and that the Respondent's expert's opinion (see below) regarding the placement of sealants over frank decay is not the standard of care, but represents a minority view. Further, we agree with the opinion that the placing of sealants over frank or obvious decay is not within the standard of care in the public health setting or in any other setting, as the dangers described in

such inappropriate sealing are present in the public health setting as in other settings.

9. The Respondent also presented an expert, Dr. Richard J. Simonsen, to testify regarding the proper use of sealants and the standard of care. A summary of his comments follows. Sealants prevent the growth of decay by cutting off oxygen and nutrients. Sealants do not themselves cause decay, even if part of the seal is lost. He noted that in the public health setting, the patient may not receive further dental care. The assumption must be made that the likelihood of further care is small, so the decision to use sealants is different in the public health setting from the private setting. If the patient has never seen a dentist, then it is not likely that he will have further care. Sealing is appropriate in situations such as these. If there is frank decay, sealant can be used, the patient and parents are advised this will not cure the problem, and they are advised to see a dentist. It was within the standard of care to use sealants in these situations (including that of companion cases to this one). In this case there was caries present, however, the Respondent did not deviate from the standard of care, but properly placed sealants and advised the patients of the problems. In these cases, the patients did see a dentist shortly after the treatment by the Respondent. This accomplished one of the goals of a school based program, which is to have students see a dentist. The placement of sealants is not harmful. The breaking of a seal does not create a problem. Even a partial sealant is better than none at all. If a child is not likely to return, it is beneficial to seal over lesions. If caries is properly sealed off, it may be retarded.

10. The Respondent presented testimony from a Department of Health and Environmental Control (DHEC) representative from the oral health program under whose aegis the school based program in this case operates. Materials were presented which included the "Guidelines for SC School-Based Dental Prevention Programs." The section on Dental Sealants reads: "All patients that have teeth with structural characteristics that place them at risk for decay should be considered for preventative sealants. Patients that have teeth with questionable decay should also be considered for sealants (therapeutic sealants). A third type of dental sealant, interim sealant, may be used in community and school based programs. These sealants are used to slow down the decay process in some teeth that have dental caries. Interim sealants are not recommended unless a dentist examines the patient and determines that the patient is unlikely

to access restorative services in the near future and the size of the lesion is not too large to preclude the procedure" (emphasis added). A second paragraph continues: "According to the proceedings of the workshop on sealant guidelines, " The goal of preventing caries through widespread use of sealants will be accomplished best by providing preventive sealants to individuals at high risk and placing therapeutic sealants on carious lesions that are limited to enamel."

11. After considering all the evidence introduced in these cases, we adopt the opinion of the State's expert and find that there is a deviation from the standard of care, regardless of setting (including the public health setting), when sealant is placed over clinically obvious decay. In the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal. We find that the evidence is clear that, as to patient M.A., the Respondent violated the standard of care. The Respondent inappropriately sealed teeth #'s 3, 15, 19, and 31. The evidence shows a large and extensive degree of decay which should have been obvious to the Respondent. The Respondent herself noted that decay was sticky throughout. Numerous fillings were subsequently required by the patient. Obvious decay was seen shortly after the Respondent's treatment by a dentist and hygienist. The Respondent's treatment of M.A. failed to meet the standard of care in the practice of dental hygiene, and was outside the range of acceptable dental hygiene practice in similar situations in that the Respondent placed sealant over obvious decay on several teeth, #'s 3, 15, 19, and 31. In the case of T.M., the evidence of obvious decay may not have been sufficiently clear to the Respondent, and we do not find a violation of the standard of care.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this case, it is found and concluded as a matter of law that:

1. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. §40-15-190, has the authority, pursuant to S.C. Code Ann. §40-15-200, to revoke or suspend a license or registration certificate, publicly or privately reprimand a licensee, or take any other reasonable action short of revocation or suspension, such as probation or the imposition of

a civil penalty of up to ten thousand dollars, or requiring the person to undertake additional professional training subject to the direction and approval of the Board, psychiatric evaluations, controlled substances restrictions, institutional practice under supervision, and any other actions considered appropriate by the Board. Upon finding that grounds for discipline exist, S.C. Code Ann. §40-1-120 provides that the Board has the authority to: issue a public reprimand; impose a fine not to exceed five hundred dollars; place a licensee on probation or restrict or suspend the individual's license for a definite or indefinite time and prescribe conditions to be met during probation, restriction, or suspension including, but not limited to, satisfactory completion of additional education, of a supervisory period, or of continuing education programs; permanently revoke a license; and impose the reasonable costs of the investigation and prosecution of a case.

2. The Respondent has violated S.C. Code Ann. §40-15-190(A)(14) in that she has failed to meet the standard of care in the practice of dental hygiene, as evidenced by her placement of sealant over obvious decay on several teeth as described above.

3. The sanction imposed is consistent with the purpose of these proceedings and has been made after weighing the public interest and the need for the continued services of qualified dental hygienists against the countervailing concern that society be protected from professional ineptitude and misconduct.

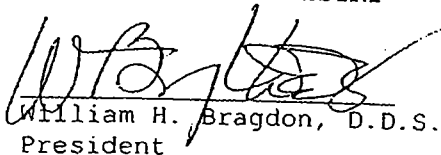
4. The sanction imposed is designed not to punish the Respondent, but to protect the welfare of the public at large.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that:

1. The Respondent be, and she hereby is, reprimanded.

AND IT IS SO ORDERED.

THE BOARD OF DENTISTRY


William H. Bragdon, D.D.S.
President

May 8, 2006.

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BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

ANONYMOUS, R.D.H.,
License No.

Respondent.

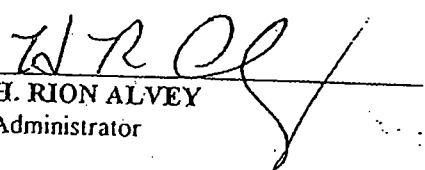
CERTIFICATE OF SERVICE

I hereby certify that I have this day served the within **FINAL ORDER** upon the person hereafter named, by depositing a copy of same in an envelope, securely wrapped in the United States Mail, Certified Mail, Return Receipt Requested, properly addressed with pre-paid postage to the said person hereafter named, at the place and address stated below, which is the last known address for the same.

Desa Ballard, Esquire
226 State St.
West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION
STATE BOARD OF DENTISTRY

BY:


H. RION ALVEY
Administrator

Columbia, South Carolina

May 16, 2006

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:)
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License No.)
Case No. 04-67)
Respondent.)

In the Matter of:)
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License No.)
Case No. 02-98, 02-99, 03-20)
Respondent.)

In the Matter of:)
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)
)
License No.)
Case No. 04-45)
Respondent.)

In the Matter of:)
)
)
)
License No.)
Case No. 03-104)
Respondent.)

ORDER DENYING MOTION

This matter comes before the Board of Dentistry for consideration of the respondents' Memorandum to the Board and Motion to Disqualify and/or for Evidentiary Hearing dated March 22, 2006. The Respondents were represented by Desa A. Ballard, Esquire, and Creighton B. Coleman, Esquire. The State was represented by Kenneth P. Woodington, Esquire.

1. The Respondents' Memorandum generally argues a number of issues, factual and legal, on the merits of these cases, but more germane to the motion requested, there is an assertion of

bias or prejudice on the part of the Board toward the Respondents. This issue was discussed to some extent before the panel which heard these cases, and the panel members were subject to voir dire regarding any prejudice they might have entertained in these cases. Nonetheless, the panel recommended dismissal of two of the four cases heard. Due to the alleged bias of the Board, the Respondents have requested that the Board be disqualified from adjudicating these proceedings, or empanel an evidentiary hearing on issues related to bias of the Board, its members, or its agents. The Board of Dentistry is directed and empowered by its practice act to hear and determine disciplinary actions against dental hygienists. S.C. Code Ann. §§40-15-180, 185, 190, and 200. The Respondents' submissions have not shown any bias or prejudice on the part of the members of the Board toward these Respondents. Similar allegations were made against the panel members who ultimately recommended dismissal of two of the cases. The Administrative Law Court, should it find the Respondents' allegations credible or material, may gather additional evidence. S.C. Code Ann. §1-23-380(A)(4). Therefore, the Respondents' motion to disqualify the Board or to empanel an evidentiary hearing to explore issues of bias is denied.

2. The Respondents further request that the Board set forth a standard of care applicable to dental hygienists working in the public health setting. This is the central issue of these cases. Contrary to the Respondents' Memorandum, the panel addressed this issue, adopting the view of the State's expert, and found in each case, "After considering all the evidence introduced in these cases, we find that there is a deviation from the standard of care, regardless of setting, when sealant is placed over clinically obvious decay." (Emphasis added). The Board has yet to consider this recommendation or the Respondents' position, and presumably will do so when the cases are argued on their merits at the final order hearing before the Board. Accordingly, the request of the Respondents is denied.

AND IT IS SO ORDERED.

THE BOARD OF DENTISTRY


William H. Bragdon, DMD
President

April 18, 2006.

Page 2 of 2

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:)
)
 [REDACTED] R.D.H ,)
)
 License No. [REDACTED])
 Case No. 04-67)
 Respondent.)

In the Matter of:)
)
 [REDACTED] R.D.H ,)
)
 License No. [REDACTED])
 Case No. 02-98, 02-99, 03-20)
 Respondent.)

In the Matter of:)
)
 [REDACTED] R.D.F.,)
)
 License No. [REDACTED])
 Case No. 04-45)
 Respondent.)

In the Matter of:)
)
 [REDACTED] R.D.H.,)
)
 License No. [REDACTED])
 Case No. 03-104)
 Respondent.)

ORDER DENYING MOTION

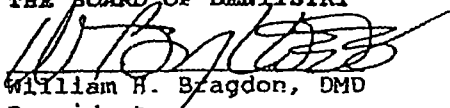
This matter comes before the Board of Dentistry for consideration of the Respondents' Motion for Copy of Initial Complaint dated April 1, 2006. The Respondents were represented by Dea A. Ballard, Esquire, and Creighton B. Coleman, Esquire. The State was represented by Kenneth P. Woodington, Esquire.

1. The Respondents in this motion request copies of the initial complaints in each of these matters prior to the Board's final order in these proceedings. The Respondents claim that the failure to provide a copy of the initial complaints against

them is a violation of their rights under the state and federal constitutions. As this is an issue of importance to both the State and to the Respondents, arguments on this issue should be presented to the full board at its hearing on April 29, 2006. Therefore, the Respondents' Motion for Copy of Initial Complaint dated April 6, 2006 is denied, and this issue is postponed for argument before the Board at the hearing on April 29, 2006.

AND IT IS SO ORDERED.

THE BOARD OF DENTISTRY


William H. Bragdon, DMD
President

April 18, 2006.

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

R.D.H.,

License No.

Case No. 03-104

Respondent.

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) PANEL REPORT AND RECOMMENDATION
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This matter came before a panel appointed pursuant to S.C. Code Ann. §40-1-90(A) for the Board of Dentistry (the Board) for hearing on December 2, 2005, as a result of the Formal Accusation and Notice of Hearing dated October 28, 2004 and October 24, 2005, which were served upon the Respondent and filed with the Board. The hearing was held pursuant to S.C. Code Ann. §§40-15-180 and 200, as amended, S.C. Code Ann. §40-1-70(6), and the provisions of the Administrative Procedures Act (the APA), S.C. Code Ann. §1-23-10, et seq. (1976), as amended. The State was represented by Kenneth P. Woodington, Esquire. The Respondent appeared with counsel, Desa A. Ballard, Esquire, and Creighton B. Coleman, Esquire.

The Respondent was charged with violation of S.C. Code Ann. §40-15-190(A) (14).

FINDINGS OF FACT

Based upon the preponderance of the evidence on the whole record, the facts of the case are found to be as follows:

1. The Respondent is currently licensed as a hygienist in South Carolina, and was so licensed at all times relevant to the issues raised in this matter.
2. On September 2, 2003, the patient Q.G. was seen by Dr. Benjamin S. Adams. The child was examined and given a cleaning (a "prophy"). The dentist's hygienist noted that the child had "rampant decay." The dentist also testified that the decay was not incipient decay but was frank (manifest or evident) decay which should have been evident to the Respondent. He stated that the decay could be seen with the eyes.

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3. On September 18, 2003, the Respondent, while employed by Health Promotion Specialists, saw the patient, conducted a medical history, cleaned the teeth (a "prophy"), applied fluoride, and placed sealants over teeth #s 3, 14, 19, and 30. The Respondent coded the condition of the teeth as a code 10, meaning there is no obvious problem. The Respondent's records indicated that Dr. Adams was the child's dentist, and a prior cleaning had been performed earlier in the year.

4. On October 7, 2003, the patient returned to Dr. Adams. His record noted that sealants have been placed on teeth #s 3, 14, 19, and 30, which had previously been described as having rampant decay.

5. The Respondent's expert testified that in this case the caries was incipient and not gross. He stated that the sealants placed on the four teeth at issue were within the standard of care for a child in a public health setting.

6. Expert and other evidence given in the first of four companion cases was presented in full in the first case and preserved for application to subsequent cases. A summary of a portion of that evidence is repeated below for purposes of evaluating this case.

7. The State's expert testified as to his opinion of the standard of care regarding the placement of sealants. He stated that the placing of sealants over frank decay is not within the standard of care. He stated that hygienists should be able to detect gross decay which has reached the dentin. The use of their explorer (a probing instrument), light, color, texture, obvious breaks, and haloing are diagnostic.

8. The State's expert, Dr. William Daniel Sneed, discussed the proper use of sealants when decay is present. Sealant may be appropriate when there is small incipient decay. Use may be appropriate if decay is small and very defined in pits and fissures, and there is no indication of reaching the DEJ (dentinoenamel junction, the surface at which the enamel and the dentin of the crown of a tooth are joined). A good seal is difficult to obtain. As the area of decay becomes larger, there is the loss of good enamel to which the sealant can adhere. If done properly under these limited circumstances, the growth of decay may

ROA Ct. of Appeals

be inhibited. When decay spreads to the DEJ or becomes too large, it is difficult to achieve a hermetic seal. A seal must reach beyond the decay to solid enamel to adhere. If there is frank decay, sealing is not indicated and decay may spread. This view is supported in the professional literature and among the expert's peers. There are minimal references to the placement of sealants over frank decay in the literature, and it is not the standard of care. The expert testified that if a hygienist encounters gross decay, the patient and parent should be advised to see a dentist for a restoration. Placing sealants over frank decay may give a false sense of security. If the seal breaks, since the teeth will be coated by the sealant, the decay will be difficult to see. It will not be black, but white, and the problem may be ignored.

9. The Respondent also presented an expert, Dr. Richard J. Simonsen, to testify regarding the proper use of sealants and the standard of care. A summary of his comments follows. Sealants prevent the growth of decay by cutting off oxygen and nutrients. Sealants do not themselves cause decay, even if part of the seal is lost. He noted that in the public health setting, the patient may not receive further dental care. The assumption must be made that the likelihood of further care is small, so the decision to use sealants is different in the public health setting from the private setting. If the patient has never seen a dentist, then it is not likely that he will have further care. Sealing is appropriate in situations such as these. If there is frank decay, sealant can be used, the patient and parents are advised this will not cure the problem, and they are advised to see a dentist. It was within the standard of care to use sealants in these situations (including that of companion cases to this one). In this case there was incipient caries present, however, the Respondent did not deviate from the standard of care by placing sealants on these four teeth. The treatment was within the standard of care for a child in a public health setting. In this case, the patient did see a dentist shortly after the treatment by the Respondent. This accomplished one of the goals of a school based program, which is to have students see a dentist. The placement of sealants is not harmful. The breaking of a seal does not create a problem. Even a partial sealant is better than none at all. If a child is not likely to return, it is beneficial to seal over lesions. If caries is properly sealed off, it may be retarded.

ROA Ct. of Appeals

10. The Respondent presented testimony from a Department of

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Health and Environmental Control (DHEC) representative from the oral health program under whose aegis the school based program in this case operates. Materials were presented which included the "Guidelines for SC School-Based Dental Prevention Programs." The section on Dental Sealants reads: "All patients that have teeth with structural characteristics that place them at risk for decay should be considered for preventative sealants. Patients that have teeth with questionable decay should also be considered for sealants (therapeutic sealants). A third type of dental sealant, interim sealant, may be used in community and school based programs. These sealants are used to slow down the decay process in some teeth that have dentinal caries. Interim sealants are not recommended unless a dentist examines the patient and determines that the patient is unlikely to access restorative services in the near future and the size of the lesion is not too large to preclude the procedure" (emphasis added). A second paragraph continues: "According to the proceedings of the workshop on sealant guidelines, " The goal of preventing caries through widespread use of sealants will be accomplished best by providing preventive sealants to individuals at high risk and placing therapeutic sealants on carious lesions that are limited to enamel."

11. After considering all the evidence introduced in these cases, we find that there is a deviation from the standard of care, regardless of setting, when sealant is placed over clinically obvious decay. In the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal. We find that the evidence is clear that, as to this patient, the Respondent violated the standard of care. The Respondent's treatment of the patient failed to meet the standard of care in the practice of dental hygiene, and was outside the range of acceptable dental hygiene practice in similar situations in that the Respondent placed sealant over obvious decay on several teeth. The decay was described by the dentist's hygienist as rampant before the patient was seen by the Respondent. The Respondent coded the case as having no obvious problems when clearly a dentist's intervention was needed.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this case, it is found and concluded as a matter of law that:

ROA Ct. of Appeals

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1. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. §40-15-190, has the authority, pursuant to S.C. Code Ann. §40-15-200, to revoke or suspend a license or registration certificate, publicly or privately reprimand a licensee, or take any other reasonable action short of revocation or suspension, such as probation or the imposition of a civil penalty of up to ten thousand dollars, or requiring the person to undertake additional professional training subject to the direction and approval of the Board, psychiatric evaluations, controlled substances restrictions, institutional practice under supervision, and any other actions considered appropriate by the Board. Upon finding that grounds for discipline exist, S.C. Code Ann. §40-1-120 provides that the Board has the authority to: issue a public reprimand; impose a fine not to exceed five hundred dollars; place a licensee on probation or restrict or suspend the individual's license for a definite or indefinite time and prescribe conditions to be met during probation, restriction, or suspension including, but not limited to, satisfactory completion of additional education, of a supervisory period, or of continuing education programs; permanently revoke a license; and impose the reasonable costs of the investigation and prosecution of a case.

2. The Respondent has violated S.C. Code Ann. §§40-15-190(A)(14) in that she has failed to meet the standard of care in the practice of dental hygiene, as evidenced by her placement of sealant over obvious decay on several teeth.

3. The sanction recommended is consistent with the purpose of these proceedings and has been made after weighing the public interest and the need for the continued services of qualified dental hygienists against the countervailing concern that society be protected from professional ineptitude and misconduct.

4. The sanction recommended is designed not to punish the Respondent, but to protect the welfare of the public at large.

RECOMMENDATION

The Panel, based upon the Findings of Fact and Conclusions of Law, hereby recommends that the Board find that there has been a violation of the practice act, and impose a public reprimand and a fine of five hundred dollars.

ROA Ct. of Appeals

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THE BOARD OF DENTISTRY

RESPECTFULLY SUBMITTED.

Dr. Douglas S. Rawls
Dr. J. Benjamin Jett
Dr. Paul S. Coombs, Jr.
Dr. Charles F. Wade
Ms. Deborah P. Baker

Douglas S. Rawls, DMD
Dr. Douglas S. Rawls
Chairman of the Panel

February 6, 2006

ROA Ct. of Appeals

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BEFORE THE STATE BOARD OF DENTISTRY OF SOUTH CAROLINA

In the Matter of:

RYTA L. WOOD, R.D.H.,
License No. 2540
Case No. 03-104

OIE: 2003-104

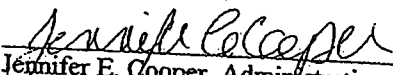
Respondent.

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be served the within Panel Report and Recommendation upon the person hereafter named, by placing the same in an envelope, securely wrapped, in the United States Mail, certified mail, return receipt requested and by regular first class mail, properly addressed to the said person hereafter named, at the place and address stated below, which is the last known address for the same:

Desa A. Ballard, Esq.
226 State St.
West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION


Jennifer E. Cooper, Administrative Assistant
LLR-Office of General Counsel
Post Office Box 11329
Columbia SC 29211 1329

2/16, 2006.

In the Matter of:

R.D.H.,

License No. [REDACTED]

Case No. 04-45

Respondent.

PANEL REPORT AND RECOMMENDATION

The Respondent was charged with violation of S.C. Code Ann. §40-15-190(A) (14).

Based upon the preponderance of the evidence on the whole record, the facts of the case are found to be as follows:

1. The Respondent is currently licensed as a hygienist in South Carolina, and was so licensed at all times relevant to the issues raised in this matter.
2. On April 11, 2003, the Respondent saw patient M. A., 14 years old, while working for Health Promotion Specialists in a school based public health setting. The Respondent's chart indicated that a medical history was taken, the teeth were cleaned (prophylaxis, or a "prophy"), fluoride was applied, and sealants were placed on teeth #s 2, 3, 14, 15, 18, 19, 30, and 31. She coded the condition of the teeth as a code 11, indicating obvious problems which require a referral to a dentist. She noted that the

teeth are "stained, decay is sticky throughout." On May 20, 2003, she recorded a call from Dr. Chadwick who treated the child after the Respondent's treatment, and she noted that she explained that the area was sticky and stained, but there were no signs of gross (unsealable) decay.

3. M.A. visited Dr. Chadwick's office on May 8, 2003 where an initial examination was made and x-rays were taken by Dr. Chadwick's hygienist who testified that gross decay could be detected visually. Dr. Chadwick placed twelve fillings that day on one side of the patient's mouth. On May 29, 2003, he placed another twelve fillings on the other side of the mouth. Photographs and x-rays were placed into evidence. Dr. Chadwick testified generally regarding the conditions he found, and specifically as to several teeth. He stated that on tooth #3 gross caries could be noted visually. When removing sealants, it was apparent to him that there was gross decay. Tooth 14 was better than the others, although the seal was not complete. Tooth 15 was partly sealed and gross decay was present down to the dentin. Tooth 31 showed gross decay into the dentin. Tooth 19 also had apparent decay. He stated that when the sealant was removed, all the teeth were grossly decayed.

4. On February 17, 2004, the Respondent saw patient T.M., a ten year old, while working for Health Promotion Specialists in a school based public health setting. The Respondent performed a history, cleaned the teeth (a "prophy"), applied fluoride, and sealed teeth #s 3, 14, 19, and 30. She noted a "slight stick greater on mesial" of # 3. She coded the teeth as a code 11, indicating obvious problems which require a referral to a dentist.

5. On February 19, 2004, the patient visited Dr. Chadwick's office, where his partner filled primary teeth and one permanent tooth, # 3. Dr. Chadwick stated that gross caries was under the sealant. The Respondent testified that she saw the decay in this case, and recommended that a dentist be seen. She did not think it was likely that the patient would have follow-up dental care. She stated that she does not routinely seal teeth in all cases, and did not seal over gross decay.

6. The State presented it's expert witness, Dr. William Daniel Sneed, to testify as to the standard of care applicable to this case (and also to three companion cases). In regard to

patient M.A., he noted on tooth # 31 some areas not sealed and a large amount of decay which reached the dentinoenamel junction (DEJ, the surface at which the enamel and the dentin of the crown of a tooth are joined). On tooth # 19, he noted obvious decay which had entered the dentin. Tooth # 15, he found not to be as clear. It was not fully sealed, and decay was suspect. Tooth # 18 had a good seal but decay is again suspect. Teeth #s 23, 19, and 31 had gross decay which was at the DEJ. On Patient T.M., he stated that tooth # 3 needed operative intervention.

7. The State's expert testified as to his opinion of the standard of care regarding the placement of sealants. He stated that the placing of sealants over frank (manifest or evident) decay is not within the standard of care. He stated that hygienists should be able to detect gross decay which has reached the dentin. The use of their explorer (a probing instrument), light, color, texture, obvious breaks, and haloing are diagnostic.

8. The State's expert discussed the proper use of sealants when decay is present. Sealant may be appropriate when there is small incipient decay. Use may be appropriate if decay is small and very defined in pits and fissures, and there is no indication of reaching the DEJ. A good seal is difficult to obtain. As the area of decay becomes larger, there is the loss of good enamel to which the sealant can adhere. If done properly under these limited circumstances, the growth of decay may be inhibited. When decay spreads to the DEJ or becomes too large, it is difficult to achieve a hermetic seal. A seal must reach beyond the decay to solid enamel to adhere. If there is frank decay, sealing is not indicated and decay may spread. This view is supported in the professional literature and among the expert's peers. There are minimal references to the placement of sealants over frank decay in the literature, and it is not the standard of care. The expert testified that if a hygienist encounters gross decay, the patient and parent should be advised to see a dentist for a restoration. Placing sealants over frank decay may give a false sense of security. If the seal breaks, since the teeth will be coated by the sealant, the decay will be difficult to see. It will not be black, but white, and the problem may be ignored.

9. The Respondent also presented an expert, Dr. Richard J. Simonsen, to testify regarding the proper use of sealants and the standard of care. A summary of his comments follows. Sealants

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prevent the growth of decay by cutting off oxygen and nutrients. Sealants do not themselves cause decay, even if part of the seal is lost. He noted that in the public health setting, the patient may not receive further dental care. The assumption must be made that the likelihood of further care is small, so the decision to use sealants is different in the public health setting from the private setting. If the patient has never seen a dentist, then it is not likely that he will have further care. Sealing is appropriate in situations such as these. If there is frank decay, sealant can be used, the patient and parents are advised this will not cure the problem, and they are advised to see a dentist. It was within the standard of care to use sealants in these situations (including that of companion cases to this one). In this case there was caries present, however, the Respondent did not deviate from the standard of care, but properly placed sealants and advised the patients of the problems. In these cases, the patients did see a dentist shortly after the treatment by the Respondent. This accomplished one of the goals of a school based program, which is to have students see a dentist. The placement of sealants is not harmful. The breaking of a seal does not create a problem. Even a partial sealant is better than none at all. If a child is not likely to return, it is beneficial to seal over lesions. If caries is properly sealed off, it may be retarded.

10. The Respondent presented testimony from a Department of Health and Environmental Control (DHEC) representative from the oral health program under whose aegis the school based program in this case operates. Materials were presented which included the "Guidelines for SC School-Based Dental Prevention Programs." The section on Dental Sealants reads: "All patients that have teeth with structural characteristics that place them at risk for decay should be considered for preventative sealants. Patients that have teeth with questionable decay should also be considered for sealants (therapeutic sealants). A third type of dental sealant, interim sealant, may be used in community and school based programs. These sealants are used to slow down the decay process in some teeth that have dentinal caries. Interim sealants are not recommended unless a dentist examines the patient and determines that the patient is unlikely to access restorative services in the near future and the size of the lesion is not too large to preclude the procedure" (emphasis added). A second paragraph continues: "According to the proceedings of the workshop on sealant guidelines, " The goal of preventing caries through widespread use

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of sealants will be accomplished best by providing preventive sealants to individuals at high risk and placing therapeutic sealants on carious lesions that are limited to enamel."

11. After considering all the evidence introduced in these cases, we find that there is a deviation from the standard of care, regardless of setting, when sealant is placed over clinically obvious decay. In the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal. We find that the evidence is clear that, as to patient M.A., the Respondent violated the standard of care. The evidence shows a large and extensive degree of decay which should have been obvious to the Respondent. The Respondent herself noted that decay was sticky throughout. Numerous fillings were subsequently required by the patient. Obvious decay was seen shortly after the Respondent's treatment by a dentist and hygienist. The Respondent's treatment of M.A. failed to meet the standard of care in the practice of dental hygiene, and was outside the range of acceptable dental hygiene practice in similar situations in that the Respondent placed sealant over obvious decay on several teeth. In the case of T.M., the evidence of obvious decay may not have been sufficiently clear to the Respondent, and we do not find a violation of the standard of care.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this case, it is found and concluded as a matter of law that:

1. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. §40-15-190, has the authority, pursuant to S.C. Code Ann. §40-15-200, to revoke or suspend a license or registration certificate, publicly or privately reprimand a licensee, or take any other reasonable action short of revocation or suspension, such as probation or the imposition of a civil penalty of up to ten thousand dollars, or requiring the person to undertake additional professional training subject to the direction and approval of the Board, psychiatric evaluations, controlled substances restrictions, institutional practice under supervision, and any other actions considered appropriate by the Board. Upon finding that grounds for discipline exist, S.C. Code Ann. §40-1-120 provides that the Board

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has the authority to: issue a public reprimand; impose a fine not to exceed five hundred dollars; place a licensee on probation or restrict or suspend the individual's license for a definite or indefinite time and prescribe conditions to be met during probation, restriction, or suspension including, but not limited to, satisfactory completion of additional education, of a supervisory period, or of continuing education programs; permanently revoke a license; and impose the reasonable costs of the investigation and prosecution of a case.

2. The Respondent has violated S.C. Code Ann. §§40-15-190(A)(14) in that she has failed to meet the standard of care in the practice of dental hygiene, as evidenced by her placement of sealant over obvious decay on several teeth.

3. The sanction recommended is consistent with the purpose of these proceedings and has been made after weighing the public interest and the need for the continued services of qualified dental hygienists against the countervailing concern that society be protected from professional ineptitude and misconduct.

4. The sanction recommended is designed not to punish the Respondent, but to protect the welfare of the public at large.

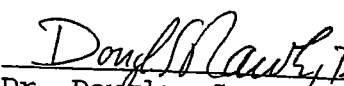
RECOMMENDATION

The Panel, based upon the Findings of Fact and Conclusions of Law, hereby recommends that the Board find that there has been a violation of the practice act, and impose a public reprimand.

RESPECTFULLY SUBMITTED.

THE BOARD OF DENTISTRY

Dr. Douglas S. Rawls
Dr. J. Benjamin Jett
Dr. Paul S. Coombs, Jr.
Dr. Charles F. Wade
Ms. Deborah P. Baker


Dr. Douglas S. Rawls
Chairman of the Panel

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February 6, 2006.

BEFORE THE STATE BOARD OF DENTISTRY OF SOUTH CAROLINA

In the Matter of:

ROBIN S. LAROCHE, R.D.H.,
License No. 1113
Case No. 04-45

OIE: 2004-45

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be served the within **Panel Report and Recommendation** upon the person hereafter named, by placing the same in an envelope, securely wrapped, in the United States Mail, certified mail, return receipt requested and by regular first class mail, properly addressed to the said person hereafter named, at the place and address stated below, which is the last known address for the same:

Desa A. Ballard, Esq.
226 State St.
West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION


Jennifer E. Cooper, Administrative Assistant
LLR-Office of General Counsel
Post Office Box 11329
Columbia SC 29211 1329

2/16, 2006.

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**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING & REGULATION
BEFORE THE BOARD OF DENTISTRY**

IN THE MATTER OF:

[REDACTED] R.D.H.

License No. [REDACTED]

Case No. 03-104

Respondent.

FORMAL ACCUSATION

THE BOARD ALLEGES:

I.

That the Respondent is currently licensed as a hygienist in South Carolina and that the Board of Dentistry has jurisdiction over Respondent and the subject matter herein.

II.

1. That sometime between September 2, 2003, and October 7, 2003, Respondent, while employed with Health Promotion Specialists, placed sealants over several teeth (3, 14, 19 & 30) of patient Q [REDACTED] G [REDACTED]
2. That upon examination by a dentist on October 7, 2003, it was found that sealant was placed over teeth that had been previously diagnosed with frankly cavitated occlusal lesions.
3. That the sealant was removed from tooth #3 and a restoration was placed.
4. That tooth #30 had been filled on March 4, 2003, and did not require a sealant.

III.

As a result of the acts and the conduct alleged herein, Respondent is charged with violation of § 40-15-190(A)(14) Code of Laws of South Carolina (1976, as amended).

IV.

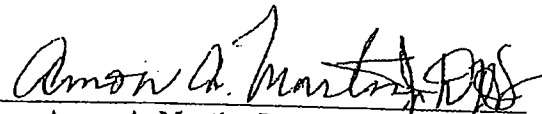
Pursuant to S.C. Code Ann. §40-15-190 (1976, as amended), the Board of Dentistry has the authority to order the revocation or suspension of a license or registration, or take other

reasonable action short of revocation or suspension. These other actions may include probation, public or private reprimand or reasonable restriction of a licensee's practice. Further, if you are found guilty, the board may assess a civil penalty of up to ten thousand dollars (\$10,000) per violation.

YOU ARE HEREBY NOTIFIED that the Board of Dentistry will conduct a hearing to hear the charges against you as stated above. You will be given a minimum of thirty (30) days notice of the hearing. The hearing is held pursuant to the authority of South Carolina Code §§40-15-190, 40-15-200, 40-1-90, 40-1-120, 40-1-130 and 40-1-170 Code of Laws of South Carolina (1976, as amended). Hearings are held in accordance with SC Code of Laws §1-23-310 et. seq. (1976, as amended), which describes your procedural rights, including but not limited to the right to respond and present evidence and argument on all issues involved. In addition, you have the right to be represented by legal counsel.

**SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING & REGULATION, BOARD OF
DENTISTRY**

BY:



Amon A. Martin, Jr., DMD, President
P. O. Box 11329
Kingstree Bldg., 110 Centerview Dr.
Columbia, SC 29211-1329
(803) 896-4599

Columbia, South Carolina

October 28, 2004

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED] R.D.H.,
License No. [REDACTED]

CERTIFICATE OF SERVICE

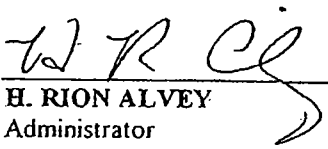
Respondent.

I hereby certify that I have this day served the within **FORMAL ACCUSATION** upon the person hereafter named, by depositing a copy of same in an envelope, securely wrapped in the United States Mail, Certified Mail, Return Receipt Requested, properly addressed with pre-paid postage to the said person hereafter named, at the place and address stated below, which is the last known address for the same.

[REDACTED]
[REDACTED]
[REDACTED]

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION
STATE BOARD OF DENTISTRY

BY:


H. RION ALVEY
Administrator

Columbia, South Carolina

November ^{re} 22, 2004

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING & REGULATION
BEFORE THE BOARD OF DENTISTRY**

IN THE MATTER OF:

[REDACTED], R.D.H.

License No. [REDACTED]

Case No.04-45

FORMAL ACCUSATION

Respondent.

THE BOARD ALLEGES:

I.

That the Respondent is currently licensed as a hygienist in South Carolina and that the Board of Dentistry has jurisdiction over Respondent and the subject matter herein.

II.

1. That on February 17, 2004, Respondent, while employed with Health Promotion Specialists, placed sealants over four (4) teeth (#s 3,14,19&30) of patient T [REDACTED] M [REDACTED]
2. That on April 7, 2004, Respondent, while employed with Health Promotion Specialists, placed sealants over eight (8) teeth (#s 2,3,14,15,18,19,30&31) of patient M [REDACTED] A [REDACTED]
3. That upon examination by patient's dentist in May of 2004, it was found that sealant was placed over gross caries on several teeth.

III.

As a result of the acts and the conduct alleged herein, Respondent is charged with violation of § 40-15-190(A)(14) Code of Laws of South Carolina (1976, as amended).

IV.

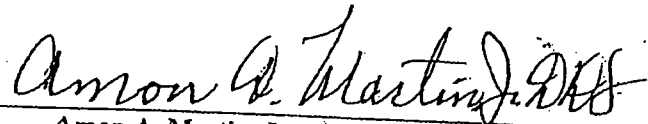
Pursuant to S.C. Code Ann. §40-15-190 (1976, as amended), the Board of Dentistry has the authority to order the revocation or suspension of a license or registration, or take other reasonable action short of revocation or suspension. These other actions may include probation,

public or private reprimand or reasonable restriction of a licensee's practice. Further, if you are found guilty, the board may assess a civil penalty of up to ten thousand dollars (\$10,000) per violation.

YOU ARE HEREBY NOTIFIED that the Board of Dentistry will conduct a hearing to hear the charges against you as stated above. You will be given a minimum of thirty (30) days notice of the hearing. The hearing is held pursuant to the authority of South Carolina Code §§40-15-190, 40-15-200, 40-1-90, 40-1-120, 40-1-130 and 40-1-170 Code of Laws of South Carolina (1976, as amended). Hearings are held in accordance with SC Code of Laws §1-23-310 et. seq. (1976, as amended), which describes your procedural rights, including but not limited to the right to respond and present evidence and argument on all issues involved. In addition, you have the right to be represented by legal counsel.

**SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING & REGULATION, BOARD OF
DENTISTRY**

BY:



Amon A. Martin, Jr., DMD, President
P. O. Box 11329
Kingstree Bldg., 110 Centerview Dr.
Columbia, SC 29211-1329
(803) 896-4599

Columbia, South Carolina

October 11, 2004

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY
Case No. 03-104

IN THE MATTER OF:

██████████ R.D.H.,

License No. ██████████

Respondent.

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ANSWER TO FORMAL CHARGES

The respondent, by and through her undersigned attorneys, hereby responds¹ to the formal charges herein, and in so doing, seeks a dismissal of these charges.

FOR A FIRST DEFENSE

1. Each and every allegation not specifically admitted herein is expressly denied, and strict proof thereof is demanded.
2. Paragraph I(1) is admitted.
3. Paragraphs II is admitted.
4. Respondent lacks sufficient information to admit or deny Paragraphs II(2) and (3) and therefore denies same. If it is determined that caries were present on any teeth at the time they were sealed, respondent would show that the standard of care supports the placement of sealants on caries to retard the development thereof until restorative work can be completed.
5. Paragraph II(4) 4 is denied.
6. Paragraph III is denied.
7. Paragraph IV is an allegation of law to which no response is required. To the extent that paragraph IV alleges any factual matters, those are expressly denied.

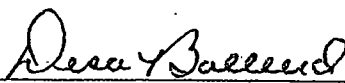
¹ No response is required by statute or regulation, but is provided for the benefit of the panel and court.

BY WAY OF MOTION

8. Each and every paragraph set forth above is incorporated herein where relevant as fully as if repeated herein verbatim.
9. Pursuant to S. C. Code Section 41-15-180(1), the Board may receive complaints against licensed hygienists, but such complaints are required to be in the form of an affidavit. On or about October 7, 2005, counsel for respondent requested copies of the complaints filed against the appellants herein. The Board administrator refused appellants' request on October 12, 2005. Review of the Administrator's decision was sought from the Administrative Law Court, which was unable to address the issue because of its interlocutory nature.
10. Respondent moves the panel and the Board for production of a copy of any and all complaints filed against respondent in this matter.

Wherefore, having fully set forth her response to the formal charges, respondent moves for an order:

- A. Dismissing the charges against her; and
- B. Producing a copy of all complaint(s) filed against respondent with the Board.


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Creighton@cbcoleman-llc.com

West Columbia, South Carolina
November 30, 2005

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SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY
Case No. 04-45

IN THE MATTER OF:)

██████████, R.D.H.,)

License No. ██████████)

Respondent.)

ANSWER TO FORMAL CHARGES

The respondent, by and through her undersigned attorneys, hereby responds¹ to the formal charges herein, and in so doing, seeks a dismissal of these charges.

FOR A FIRST DEFENSE

1. Each and every allegation not specifically admitted herein is expressly denied, and strict proof thereof is demanded.
2. Paragraph I(1) is admitted.
3. Paragraph II(1) is admitted.
4. Paragraph II(2) is denied.
5. Paragraph II(3) is denied. In the alternative, if it is determined that caries were present on tooth #3 at the time it was sealed, respondent would show that the standard of care supports the placement of sealants on caries to retard the development thereof until restorative work can be completed.
6. Paragraph III is denied.
7. Paragraph IV is an allegation of law to which no response is required. To the extent that paragraph IV alleges any factual matters, those are expressly denied.

¹ No response is required by statute or regulation, but is provided for the benefit of the panel and court.

BY WAY OF MOTION

8. Each and every paragraph set forth above is incorporated herein where relevant as fully as if repeated herein verbatim.
9. Pursuant to S. C. Code Section 41-15-180(1), the Board may receive complaints against licensed hygienists, but such complaints are required to be in the form of an affidavit. On or about October 7, 2005, counsel for respondent requested copies of the complaints filed against the appellants herein. The Board administrator refused appellants' request on October 12, 2005. Review of the Administrator's decision was sought from the Administrative Law Court, which was unable to address the issue because of its interlocutory nature.
10. Respondent moves the panel and the Board for production of a copy of any and all complaints filed against respondent in this matter.

Wherefore, having fully set forth her response to the formal charges, respondent moves for an order:

- A. Dismissing the charges against her; and
- B. Producing a copy of all complaint(s) filed against respondent with the Board.


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West Columbia, South Carolina
November 30, 2005

JP

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND
REGULATION
BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED], R.D.H.

License No. [REDACTED]

No. 04-67

Respondent.

In the Matter of:

[REDACTED], R.D.H.,

License No. [REDACTED]

Nos. 02-98, 02-99, 03-20

Respondent.

In the Matter of:

[REDACTED], R.D.H.

License No. [REDACTED]

No. 04-45

Respondent.

In the Matter of:

[REDACTED], R.D.H.

License No. [REDACTED]

No. 03-104

Respondent.

MEMORANDUM OF
LLR COUNSEL TO BOARD

STATEMENT

The undersigned counsel for the Department of Labor, Licensing and Regulation hereby submits the following Memorandum in support of the Report and

Recommendations of the Panel in each of these matters, and in opposition to the Memoranda filed by counsel for Respondents [REDACTED], R.D.H. and [REDACTED] R.D.H.

PROCEDURAL BACKGROUND

These cases were tried together before a hearing panel on December 3 and 3, 2005. The cases involved allegations that four dental hygienists working in public school settings had placed sealants over gross tooth decay in a total of seven different patients. (At the hearing, LLR counsel withdrew one of the charges against [REDACTED] Tr., p. 8.) The allegations involving each patient are separate from each other, so in effect the panel heard six different cases, even though only four hygienists were involved. By agreement of the parties and the panel, the expert testimony presented by both sides, to the extent it was of general application, was permitted to be applied in the cases of all four hygienists.

On February 6, 2006, the panel issued four written reports and recommendations, one for each of the four hygienists. Two of the reports, those for [REDACTED] and [REDACTED] discussed two separate patients, while the other two reports, those for [REDACTED] and [REDACTED] involved only patient apiece. In the cases of four of the six patients, the panel recommended that the Board those matters be dismissed. In the cases of the other two patients, one of whom was seen by [REDACTED] and the other by [REDACTED], the panel found violations of the standard of care. The panel recommended that Ms. [REDACTED] be given a public reprimand and a fine of \$500, and that Ms. [REDACTED] be given a public reprimand, but not fined. The results of the cases are summarized in the chart below:

Respondent	Patient	Examining Dentist	Panel Recommendation
[REDACTED]	[REDACTED]	Benjamin Adams (Greenville)	Pub. Reprimand, \$500
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	Stephen Chadwick (Hanahan)	Public reprimand only
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	Stephen Chadwick (Hanahan)	No violation of std. of care
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	James G. Padgett (Greenwood)	No violation of std. of care
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	Gray Ackerman (Greenwood)	(Withdrawn by LLR counsel)
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	Gray Ackerman (Greenwood)	No violation of std. of care
[REDACTED]	[REDACTED]		
[REDACTED]	[REDACTED]	James G. Padgett (Greenwood)	No violation of std. of care

The position of LLR counsel in these matters is that the panel's recommendations should be accepted in all of the cases. The panel carefully weighed the evidence in the cases of all six patients. While the position of LLR counsel about standard of care violations was not accepted by the panel in the cases of four of the six patients, LLR counsel does not now contest the panel's recommendations in those four cases. In the other two cases, those in which the panel did find a violation of the standard of care, LLR counsel submits that the panel's recommendations about imposing a sanction should be accepted by the Board, for the reasons set forth herein.

FACTS

1. [REDACTED] case (patient Q [REDACTED] G [REDACTED]).

This matter involves a patient (Q [REDACTED] G [REDACTED] who was approximately 12 years old at the time in 2003 when the events occurred that are the subject of this case. Q [REDACTED] G [REDACTED] was a patient of Dr. Benjamin Adams, a dentist in Greenville. Dr. Adams first saw this patient in February and March 2003, at which time he diagnosed decay in tooth 30. As a result, Dr. Adams did an occlusal composite restoration on that tooth on March 4, 2003. [REDACTED] Tr. 7, lines 18-20.

The patient returned to Dr. Adams on September 2, 2003. At that time Dr. Adams noted that there was "rampant decay" in the patient's mouth. His chart (LLR Exhibit 12) shows that he planned to do restorations on eleven different teeth, including #s 3, 14, 19 and 30. He also planned to seal several other teeth that were decay-free at the time.

On September 18, 2003, shortly after this examination of the patient by Dr. Adams, the patient was seen by Respondent [REDACTED] in connection with the public health dentistry program at his school. Ms. [REDACTED] placed sealants over teeth #s 3, 14, 19, and 30, all of which had previously, just a few days before, diagnosed by Dr. Adams as having decay and in need of restoration.

At the hearing, Dr. Adams was asked about his observations about the level of decay present on the four sealed teeth, i.e., teeth #s 3, 14, 19 and 30 prior to their having been sealed. He testified as follows:

Q. Okay. Do you recall from memory what the level of decay was on those ones that you just called out? And I can really just limit it to the . . . because the only ones that were [subsequently] sealed, I think, were 3, 14, 19 and 30, I believe.

A. Well, clinically speaking, you don't know the depth of it, but using my explorer and visualization, I immediately diagnosed all those teeth [i.e., 3, 14, 19 and 30] as having decay. Using my explorer, my sharp explorer with a light touch, I got a stick, as Dr. Sneed said, just like leather-like, put it in leather and it pulls back and you get a little stick, on all those. Also visualizing, especially number 3, number 3's the one that I definitely recall seeing a dark halo on the occlusal surface from the decay present.

██████ Tr. 11, lines 3-14 (emphasis added). Dr. Adams further testified as follows:

Q. Would you characterize the decay that you observed on 9/2/03, how would you characterize that decay in terms of frank or incipient or somewhere in between?

A. It was frank. I would consider it frank because just with my naked eyes I could see a halo, an obvious halo, caused by decay on his virgin teeth. There was no question in my mind.

██████ Tr. 12, line 21 through 13, line 4). Dr. Adams also agreed that the decay he observed a few weeks before the sealants were placed "should... have been apparent to the hygienist who applied the sealants." ██████ Tr. 13, lines 16-18. His basis for saying this was the presence of an obvious halo of decay, visible to the eye. ██████ Tr. 13, lines 1-4, 19-21.

On October 7, 2003, several weeks after the sealants were placed by Ms. ██████, the patient returned to Dr. Adams' office. Sealants had been placed on all four of the molars that Dr. Adams had previously diagnosed as being frankly decayed, with such decay apparent to Dr. Adams using no tools other than the explorer and the naked eye. Dr. Adams took a color intra-oral photograph of the four sealed teeth. LLR Ex. 13. During that October 7 visit, Dr. Adams only filled one of the four molars, tooth # 3. On that tooth, he removed the sealant and performed a fissurotomy. He took another intra-

oral photograph of just tooth # 3 after the fissurotomy, and then one more photograph of the same tooth following further caries excavation (both photos are also part of LLR Ex. 13). The photo after the fissurotomy and prior to the excavation confirmed to Dr. Adams the correctness of his previous diagnosis of frank decay, based on explorer probing and naked-eye observation. [REDACTED] Tr. 15, lines 14-17.

Dr. Adams restored tooth # 3, but did not do any work at all on the other sealed molars. The patient did not return to Dr. Adams' office after the October 7, 2003 visit.

2. [REDACTED] case (patient M [REDACTED] A [REDACTED]).

This matter involves patient M [REDACTED] A [REDACTED], who was about 14 when the events occurred. That patient was seen on April 7, 2003 by Respondent [REDACTED], who on that date placed sealants over the patient's permanent molars.¹

About a month later, on May 8, 2003, the patient was seen for the first time by a dentist, Dr. Steven Chadwick. On that date, Dr. Chadwick's hygienist took intra-oral photographs of teeth 2, 3, 14, 15, 18, 19, and 31. These photographs were introduced collectively as LLR Exhibit 3. Each photograph was numbered to correspond with the number of the tooth photographed. [REDACTED] Tr. 53, lines 3-7. Dr. Chadwick testified that decay was visually apparent on the following teeth even with the sealants in place:

Tooth #3: [REDACTED] Tr. 55-56, and Ex. 3, photo 3.

Tooth #14: [REDACTED] Tr. 57, and Ex. 3, photo 14.

Tooth #15: [REDACTED] Tr. 57, and Ex. 3, photo 15.

Tooth #31: [REDACTED] Tr. 59, and Ex. 3, photo 31.

Tooth #19: [REDACTED] Tr. 59-60, and Ex. 3, photo 19.

¹ Ms. [REDACTED]'s chart indicates that sealants were applied to teeth 2, 3, 14, 15, 18, 19, 30 and 31.

Dr. Chadwick eventually removed the sealants and filled these and other decayed teeth.

Tr. 49-51.

Dr. Sneed also reviewed the photographs of this patient's teeth and concluded that there was obvious decay, visible even through the sealants, on teeth 31, 19, 15, 23, and perhaps 18. Tr. 112-120.

ARGUMENT

1. There was ample evidence that both Respondents placed sealants over obvious decay.

A. case (patient O. C.).

The panel found as a fact that Ms. "placed sealant over obvious decay on several teeth." Report and Recommendation, p. 4, Par. 11. The testimony of the examining dentist, Dr. Adams, about this patient provides ample evidence to support this conclusion. That testimony has been summarized and quoted in detail hereinabove. Respondent quarrels with this diagnosis, but can point to no cogent reason why it should be disregarded. LLR counsel would submit that the panel's findings regarding the presence of visible decay, diagnosed before the teeth were sealed, and reaffirmed by the examining dentist's testimony and by at least one intra-oral photograph, is the most reasonable, and probably the only reasonable, conclusion that can be drawn about the teeth of this patient at the time the sealants were applied.

Also unavailing are Respondent's contentions that the panel did not adequately analyze the evidence. The panel in fact concluded after setting forth the testimony of all sides that "the evidence is clear that, as to this patient, the Respondent violated the

standard of care. . . . in that the Respondent placed sealant over obvious decay on several teeth." [REDACTED] Report and Recommendation, p. 4, Par. 11.²

Finally, Respondent makes an unfounded claim that the Formal Accusation in this case pertained only to tooth # 3. While Paragraph II(3) of the Formal Accusation refers specifically to tooth # 3, the preceding sentence, found in Paragraph II(2), alleges that the October 7, 2003 examination revealed that "sealant had been placed over teeth that had been previously diagnosed with frankly cavitated occlusal lesions." Respondent's claim that this case should only involve tooth # 3 is therefore without merit.

B. [REDACTED] case (patient M [REDACTED] A [REDACTED])

The panel found as a fact that "[t]he evidence shows a large and extensive degree of decay which should have been obvious to the Respondent." [REDACTED] Report and Recommendation, p. 5, Par. 11. The panel had previously summarized the testimony of Dr. Chadwick and of Dr. Sneed with reference to specific teeth. [REDACTED] Report and Recommendation, p. 2-3, Paragraphs 3 and 6. Reading the Report and Recommendations as a whole, it is clear that, at a minimum, Respondent was found to have placed seals improperly over teeth #s 3, 14, 15, 31 and 19.³

Respondent claims that the testimony was not specific enough as to the teeth which were improperly sealed. This contention is without merit. The testimony and photographs, as already summarized, identified the teeth that were visibly decayed and that were sealed over that decay.

² This statement clearly embodies a finding that the decay was obvious. However, if the Board were to conclude that a more specific finding about the obviousness of the decay is necessary, the Board, if it agrees with the panel, could include such a finding in its Final Order.

³ As with the [REDACTED] case, the Board could list specific teeth in its findings if it agrees with the panel that sealants were placed over obvious decay.

2. The standard of care for dental hygienists, regardless of the setting in which they practice, is that sealants should not be placed over frankly or obviously decayed teeth.

Dr. William D. Sneed, professor and Chairman of the Department of General Dentistry at MUSC, testified with respect to the standard of care where sealants are placed by dental hygienists. His testimony can be summarized as follows:

1. There is only one standard of care in South Carolina with respect to the placement of sealants by dental hygienists over frank cavitation. [REDACTED] Tr. 121, lines 19-23. That standard of care applies in both public health settings and in private dental offices. *Id.* at 122, lines 5-8.
2. That standard of care is that sealants should not be placed over decay which is frank, i.e., involving gross carious lesions. *Id.* at 122, lines 2-4.
3. A dental hygienist should be able to detect frank cavitation on a molar. *Id.* at 122, lines 9-15. The tools available to hygienists for making this determination include visual examination with the naked eye and the use of explorer tools. *Id.* at 123, line 13, through 126, line 12.

Dr. Sneed further testified that the reasons for not placing sealants over frank decay are that

... you'd give a false sense of security to the patient and to the parent. . . . [I]t would be very difficult to achieve a hermetic seal, a very good seal.

* * *

And if it breaks, if that seal breaks and you've left decay, it is rampant. It becomes . . . in a matter of months you could have an exposure, a toothache, a root canal. So my concern with sealing a frankly cavitated lesion would be just that. You might get a sealant right now possibly, you may very well, but is it going to stay there. We see it all the time, a portion comes loose, now it leaks; the patient has a false sense of security, it's an opaque sealant, mama sees something white on there, it looks fine, and it may progress

extremely rapidly. The same thing happens with a cracked filling. If you have a cracked amalgam and the amalgam is loose but won't fall out, that's the worst possible scenario, because now it's leaking, saliva, bacteria, sugar, so forth are getting up under there.

Tr. 131, lines 16-20; 132, line 24 through 133, line 17. Dr. Sneed reiterated these points at pp. 139-140 of the transcript.

In contrast to this cogent testimony of Dr. Sneed, the expert retained by the Respondents, Dr. Simonson, staked out an extreme position with respect to the placement of sealants. He testified that "it is okay to place sealant under any circumstances."

Tr. 205, lines 18-19. He had previously, however, told Dr. Sneed in an e-mail exchange over a year before the hearing that caries could progress under an inadequately placed sealant, thereby leading both to increased decay and a false sense of security on the part of the patient and the parent. Tr. 217, lines 7-15. While Dr. Simonson attempted to qualify these remarks at the hearing, his e-mail, presumably written before he was retained by Respondents to testify in this case, makes it clear that he and Dr. Sneed are in agreement that it is inappropriate to place sealants over frank cavitation.

Respondents attempt to make these cases unduly complicated. No matter where a dental hygienist practices, however, there are minimal requirements of competence and professional standards that must be observed. Among those standards is the avoidance of sealing frankly decayed teeth when the decay is readily apparent to a hygienist using the tools available to a hygienist. Contrary to the claims the Respondents have made, compliance with this minimal standard of practice should not "chill" the public health dental hygiene program. The panel was careful to note that the hygienists were not required to find decay when decay was not apparent to them using the tools they had available to them. Thus, for instance, in a case where x-rays showed decay, the panel was

not willing to find that the hygienist should have spotted the decay, because "this [radiographic evidence] would not have been available to the Respondent when she conducted her examination." [REDACTED] Report and Recommendations, p. 2, Par. 4. Thus, the panel concluded that "[I]n the settings involved in this and companion cases, it is especially important to determine what the hygienist was able to or should have been able to determine with the means at her disposal." See, e.g., [REDACTED] Report and Recommendations, p. 5, Par. 11. These cases, taken together, stand for the idea that a hygienist should be able to spot frank cavitation via the naked eye and/or the use of an explorer, and that when such cavitation is seen, the hygienist should not seal the tooth. This is a minimal standard of care, but it is a clear one, and it is one that was violated in the two instances in which the panel recommended a sanction.

3. Proof of actual harm to a specific nature is not an element of a professional disciplinary proceeding.

Respondents argue that in the absence of a showing of harm to the patients, there can be no finding of professional misconduct. This contention fails to take into account the difference between a professional disciplinary proceeding and a professional malpractice claim. In a malpractice case, the patient is seeking to recover damages because of harm actually done to him by the actions of the professional. In that context, the plaintiff can recover damages only if he actually suffers harm. If the professional commits a major practice error, such as a mistake in the course of surgery, but that mistake is corrected in time to avoid doing any harm at all to the patient, then the patient can recover no damages because no harm has been done to him. Another example of substandard care not causing harm in a particular case would be the prescription of a contraindicated drug, which for some reason did not actually harm the specific patient

who took it, or which for some reason was not even taken by the patient. In this latter example, the professional erred, even though for some intervening reason, the error did not harm the patient.

The purpose of professional disciplinary proceedings in cases of this kind is to protect the public from substandard professional care. Thus, if a professional were to dispense clearly contraindicated medicine to a number of patients who were not harmed, the fortuitous fact that the patients were lucky enough not to suffer harm would not lessen the professional misconduct. It is therefore clear that professional misconduct is not excused simply because for some reason the patient did not suffer harm. Of course, in the present two cases, no harm was suffered to at least some of the teeth of the patients for the simple reason that they went to dentists not long after the sealants were placed, and had the sealants removed and the teeth restored. The sealants were not necessarily on those teeth long enough for any harm to be done.

4. Respondents are not entitled to copies of the initial complaints.

Respondent also has filed a motion claiming a right to see the initial complaint filed in this matter. LLR counsel submits that this request by Respondents should be denied.

Respondent has argued that this case is identical to the Medical Board case of *South Carolina Department of Labor, Licensing and Regulation v. Girgis*, 332 S.C. 162, 503 S.E.2d 490 (Ct. App. 1998). However, the statutes requiring that information in Dental Board cases be kept confidential are different from the Medical Board statutes applied in *Girgis*. That Medical Board statute contained the following language, which is absent from the Dental Practice Act:

No part of this article shall be construed as prohibiting the respondent or his legal counsel from exercising the respondent's constitutional right of due process under the law, nor to prohibit the respondent from normal access to the charges and evidence filed against him as a part of due process under the law.

332 S.C. at 169, 503 S.E.2d at 493-494, quoting §40-47-212 (emphasis in original). The absence of similar language in the Dental Practice Act renders *Girgis* inapposite.⁴

Moreover, even if the statutes had been identical, LLR submits that *Girgis*, a Court of Appeals case, was wrongly decided. The initial complaint in a professional licensing case is neither "the charges" nor "evidence" in such a case unless it is introduced into evidence at the Panel Hearing. The "charges" are the Formal Complaint or Formal Accusation served on the licensee by LLR, and the "evidence" is whatever is received as evidence by the hearing officer or hearing body. LLR counsel did not introduce the initial complaints into evidence in these cases. Those initial complaints served merely to cause the initiation of investigations by LLR. The facts found in the course of those investigations, not the contents of the initial complaints, provide the bases for the filing of formal charges by LLR. The evidence on which the panel made its recommendations was all placed before the panel, and neither the panel nor this Board have seen the initial complaint. This constitutes one more reason why there is no right in the licensee to obtain a copy of the initial complaint.

⁴ In the other case which Respondent has previously cited on the issue of initial complaints against licensees, *Hainer v. American Medical Intern., Inc.*, 320 S.C. 316, 465 S.E.2d 112 (Ct. App. 1995), the opinion of the Court of Appeals does not indicate how the identity of the initial complainant became known. The case accordingly had nothing to say about whether such information was required to be disclosed by the licensing board.

Finally, it should be noted that in 2005, the General Assembly effectively abrogated any requirement of *Girgis* that the initial complaint must be supplied to the licensee, even in Medical Board cases. Section 40-47-213(A)(2), as amended by Act No. 150 of 2005, provides that

The name of the initial complainant must be provided to the licensee who is the subject of the complaint, investigation, or proceeding unless the board, hearing officer, or panel determines there is good cause to withhold that information.

(Emphases added.) This amendment of the Medical Practice Act clearly indicates that the General Assembly has never intended for the initial complaint itself to be supplied to the licensee; indeed, the amended Medical Practice Act even allows the Medical Board to withhold the identity of the complainant if there is good cause to do so. The amendment therefore provides another reason why Respondents should not be provided with the initial complaints in these cases.

CONCLUSION

For the foregoing reasons, LLR counsel respectfully submits that the findings, conclusions, and recommendations of the hearing panel in this case should be adopted by the Board, subject to any additional findings or conclusions the Board might want to make that support the same result recommended by the panel. LLR counsel also submits that all motions filed by Respondent, to the extent such motions are still pending, should be denied.

Respectfully submitted,

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION

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April ___, 2006

BY: _____

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ATTORNEYS for the South Carolina
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SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY
Case No. 04-67

IN THE MATTER OF:

██████████, R.D.H.,

License No. ██████████

Case No. 04-67

Respondent.

RENEWAL OF RESPONDENTS'
MOTION FOR COPY OF INITIAL COMPLAINTS

IN THE MATTER OF:

██████████, R.D.H.,

License No. ██████████

Case No. 02-98, 02-99, 03-20

Respondent.

IN THE MATTER OF:

██████████, R.D.H.,

License No. ██████████

Case No. 04-45,

Respondent.

IN THE MATTER OF:

██████████, R.D.H.,

License No. ██████████

Case No. 03-104

Respondent,

Both by letter to the Board administrator and motion set forth in their answers in these proceedings, Respondents have requested copies of the complaints which were filed with the Board and started these proceedings. The Board administrator refused the request, citing Board policy. An appeal to the Administrative Law Court was stricken as interlocutory, so no ruling has been made on the merits of the request. Respondents' requests during the panel hearing for production of the complaints were denied. Respondents now renew their demand that copies of the initial complaints in these matters be produced to them. In support, Respondents would show:

Pursuant to statute, complaints filed with the respondent Board are required to be in the form of an affidavit. S.C. Code Ann. Section 40-15-180(1). The Board lacks authority to waive the requirement that an affidavit be filed by a complainant; oral complaints are not permitted. Despite prior requests, the Board administrator has refused to provide copies of the complaints.

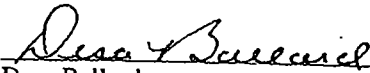
(Ex. A)

The Board has refused to provide appellants with copies of the complaints filed against them, citing both S.C. Code Ann. Section 40-15-180(3) and Section 40-15-80(4), which provide that the proceedings are confidential and that communications made with the Board are "privileged."

The failure of the respondent Board to provide a copy of the complaints against appellants is a violation of appellant's rights under the state and federal constitutions¹:

¹ Respondents are informed and believe that the filing of the instant complaints against them is in furtherance of unlawful activity by the Board and/or individual dentists and/or the South Carolina Dental Association in restraining the trade of the appellants and other licensed dental hygienists, all of which is more fully described in a complaint of the Federal Trade Commission of which this Board is assumed to be aware. At least two treating dentists in these proceedings acknowledged having filed complaints to initiate these proceedings, and in their testimony demonstrated hostility and clear bias toward the school-based dental hygienist program (although one claimed to support the program, as long as the hygienists just cleaned teeth). (Ex. A) Tr. P. 43, line 23 - p. 59, line 1; (Ex. B) Tr. P. 80-89). One even took the time to share with the panel a list all of his self-described "beefs" with the program. (Ex. C) Tr. P. 51)

Respondents renew their prior request that copies of all complaints which initiated these proceedings be produced to them prior to the Board's final order in these proceedings.


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ATTORNEY FOR RESPONDENTS

April 6, 2006



South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Dentistry

Mark Sanford
Governor

Adrienne Riggins Youmans
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October 12, 2005

Desa Ballard, Esquire
226 State Street
West Columbia, South Carolina 29169

Re: [REDACTED] n/k/a [REDACTED] Case No. 02-98, 02-99 & 03-20
[REDACTED] Case No. 04-45
[REDACTED] Case No. 03-104
[REDACTED] Case No. 04-67

Dear Ms. Ballard:

I am in receipt of your letters dated October 7 and 8, 2005, regarding your service as co-counsel with Creighton Coleman for the respondents in the above-referenced matters. In your letters, you have requested copies of the initial complaints filed against your clients.

I would refer you to Section 40-15-180 of the South Carolina Dental Practice Act. Section 40-15-180(3) states, "All investigations and proceedings undertaken under the provisions of this chapter shall be confidential." Further, Section 40-15-180(4) states, in pertinent part, "Every communication, whether oral or written, made by or on behalf of any complainant to the board or its agents, ... pursuant to this act whether by complaint or testimony, shall be privileged...."

Therefore, please be advised that this office may not release a copy of any complaint filed, as doing so would be a direct violation of the South Carolina Dental Practice Act.

Sincerely yours,

H. Rion Alvey
Administrator

HRA/tez

DDPA Received 10-14-05 ☐ hand deliver
Calculated 10-14-05 ☐ express/overnight
Archived 10-14-05 ☒ U.S. mail
Ticked ☐ fax
Copy / Fax / Email to
Done Sub file





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Desa Ballard
Certified Mediator
also admitted in D.C.

Jason B. Buffkin

Stephanie Weissenstein

226 State Street
West Columbia, SC 29169

April 6, 2006

Via U.S. Mail Only
Rion Alvey
Board of Dentistry
110 Centerview Drive
Kingtree Building
Columbia, South Carolina 29210

Re: [REDACTED] n/k/a [REDACTED] Case No. 02-98, 02-99 & 03-20
[REDACTED], Case No. 04-45
[REDACTED], Case No. 03-104
[REDACTED], Case No. 04-67

Dear Rion:

Enclosed for filing is our Renewal of Respondents' Motion for Copy of Initial Complaint in the referenced matters. I would appreciate you submitting this to the Board prior to our hearing on April 29, 2006.

With warm personal regards, I am,

Sincerely yours,

Desa Ballard

Desa Ballard
desab@desaballard.com

c: ✓ Kenneth P. Woodington, Esquire
Louis Rosen, Esquire
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY

Case No. 04-67

IN THE MATTER OF:

[REDACTED], R.D.H.,

License No. [REDACTED]

Case No. 04-67

Respondent.

IN THE MATTER OF:

[REDACTED], R.D.H.,

License No. [REDACTED]

Case No. 02-98, 02-99, 03-20

Respondent.

IN THE MATTER OF:

[REDACTED], R.D.H.,

License No. [REDACTED]

Case No. 04-45,

Respondent.

IN THE MATTER OF:

[REDACTED], R.D.H.,

License No. [REDACTED]

Case No. 03-104

Respondent,

RESPONDENTS' MEMORANDUM
TO THE BOARD AND
MOTION TO DISQUALIFY AND/OR
FOR EVIDENTIARY HEARING

Respondents named above submit this memorandum to the Board for consideration in advance of the consideration of the Report and Recommendations of the hearing panel in each of the referenced cases dated February 6, 2006. Respondents specifically move for an order from the Board disqualifying itself from adjudicating these actions, or conducting an evidentiary hearing on issues related to bias. Additionally, respondents submit that these proceedings cannot proceed in the absence of a determination by an unbiased adjudicatory body of the applicable standard of care under the facts presented here.

All Respondents are licensed dental hygienists, employed by Health Promotion Specialists, a private company which contracts with school districts around the state to provide preventative dental care to students in the public schools.

In 1988, the General Assembly enacted legislation aimed at increasing the availability of preventative dental care for school aged children, both for children who receive Medicaid and those who have private insurance. 1988 Act No. 439. The 1988 act allowed licensed dental hygienists to provide preventative dental care for children in public schools. The program was not particularly effective, largely because the enabling legislation required a dentist to examine each student before the hygienists were able to provide services. (Opinion and Order of the Commission dated July 30, 2004¹) (hereinafter referred to as FTC order), p. 6.

As a result, in 2000 the General Assembly amended the law to eliminate the need for examination by a dentist prior to the provision of preventative dental treatment. 2000 Act No. 298. It further allowed the hygienists to perform certain preventative dentistry procedures to

¹ The FTC filed charges against the South Carolina Dental Board which allege that the Board has acted illegally in depriving children in South Carolina of preventative dental care. *In the Matter of the South Carolina State Board of Dentistry*, FTC Docket No. 9311 (September 15, 2003). The cited order was issued by the FTC in response to a motion to dismiss filed by the Board. The matter is currently pending on appeal before the Fourth Circuit Court of Appeals.

2 

students "in school settings . . . under general supervision²." S. C. Code Ann. Section 40-15-80(B)³. Thus, the preventative dental care is provided by the hygienists under procedures established and monitored by the general supervision of dentists associated with the program.

In 2003, the General Assembly amended the law again to clarify that the pre-examination requirement did not apply in public health settings⁴. In so doing, the General Assembly thereby recognized that the school-based public health setting is different, both in theory and in application, than the setting of a private dentist's office, and that therefore, different rules apply. The filing of these complaints, and the proceedings to date, reflect the Board's lack of understanding as to the purposes and procedures employed preventative dental care in a public health setting, and the standard of care applicable to the treatment rendered by dental hygienists in this setting.

STANDARD OF CARE

These cases cannot be adjudicated without recognizing the different standard of care applicable to the public health school setting and evaluating the care provided by the respondents here in that light. Respondents presented significant testimony regarding the purposes of the

² "'General supervision' means that a licensed dentist on the South Carolina Department of Health and Environmental Control's public health dentist has authorized the procedures to be performed but does not require that a dentist be present when the procedures are performed." Section 40-15-85(2).

³ In July 2001, the Board enacted an emergency temporary regulation which sought to overrule the 2000 amendments, and reinstate the preexamination requirement. The emergency regulation was unsuccessfully challenged in circuit court. *Health Promotion Specialists LLC v. South Carolina Board of Dentistry*, Case No. 2001-CP-40-3148. The Board proposed a permanent regulation similar to the emergency regulation, but following a hearing before this Court, it was determined that the proposed regulation "was unreasonable and contravened state policy to the extent it reinstated the dentist preexamination requirement that the legislature had eliminated in 2000." *Public Hearing Report of the Administrative Law Judge, In re: Proposed Regulation*, Case No. 01-ALJ-11-0348-RH (Order dated 2-11-02, pp. 17-18). The Board did not submit the proposed regulation to the General Assembly and the proposed regulation therefore did not take effect. (FTC Order, p. 9).

⁴ The Board again attempted to supersede the legislature's action, which led to the filing of the FTC complaint against the Board. Fortunately for the children of South Carolina, the public health school-based dental program has continued, providing preventative dental care to tens of thousands of children who might not otherwise have received dental care.

school based dental health program, and the standards applicable to the care provided in that setting. *See discussion, infra*. The hearing panel was specifically asked to identify and set forth the standard of care applicable to the school based dental health program, before evaluating the facts and circumstances presented here. Not only did the investigative panel fail to do so, it failed to even acknowledge that the treatment provided was provided in the public health setting or that there might be a different standard applicable. The panel simply ignored the issue.

The preventative dental care provided by the dental hygienists in the school setting follow guidelines and protocols prescribed by DHEC in 2001, created as a result of a collaborative effort by DHEC (under the guidance of its dental director, Dr. Ray Lala and with funding from the Centers for Disease Control) and its dental health coalition, including representatives from the Dental Association, the Dental Hygienists Association, the Board of Education, and several advocacy groups for children. (Rec. p. 228-229). South Carolina's protocols are drawn from findings and recommendations regarding use of dental sealants in the school-based public health setting, which are uniformly applied in school-based programs throughout the United States, and are based upon the Centers for Disease Control 1994 Sealant Workshop⁵. *Id.*

South Carolina's guidelines for use of sealants in the public school setting specifically recognize that dental sealants have an established history of both preventing carious lesions as well as arresting existing caries. The guidelines provide, in part:

Sealants have been demonstrated to be a safe and effective long-term method to prevent pit and fissure caries. . . In addition to preventing carious lesions, sealants can arrest caries progression. . . Patients who have teeth with questionable decay should . . . be considered for therapeutic sealants. . . Interim dental sealant may be used in community and school-based programs. These sealants are used to slow down the decay process in some teeth that have dentinal caries. . . The goal of preventing caries through widespread

⁵ The CDC is expected to issue updated recommendations shortly addressing developments in the school-based public health dental program, which DHEC is expected to adopt as well. (Tr. P. 229).

use of sealants will be accomplished best by providing preventative sealants to individuals at high risk and placing therapeutic sealants on carious lesions that are limited to enamel.

(Resp.Ex. 6(3)). See also Rec. p. 231-232.

All children who are seen in school based dental health programs are referred to a dentist for additional and follow-up treatment, regardless of whether they are suspected to have caries. (Tr. pp. 232-233; 249-250). Unfortunately, the statistics on all school based dental programs establish that seventy-five to eighty-five percent of the children seen in the public health program have never seen a dentist prior to their first contact with the public health program. (Tr. P. 158). Additionally, only approximately fifty percent (50 %) of the children who are seen for preventative dental care by the hygienists program actually do follow up with a dentist. (Tr. P. 233). Thus, for a great many children who are seen in the school-based program, the care provided by the dental hygienists is the only dental care the children will receive. *Id.*

In assessing the standard of care for a public health program, it is critical to understand that the rate of follow-up is altogether different than in the setting of a private dentist, where there is a presumption that there will be continuous care. (Rec. p. 155-156). Because the likelihood of follow-up dental treatment in the public health setting is so small, the prevailing view regarding sealants in this setting is, "when in doubt, use sealant." (Tr. P. 156).

When you have a group of individuals who are not in continuous care, you are much more . . . lavish in determining when to seal. In Atlanta [the CDC] in '95, the public health representative is stating when in doubt in a public health setting, seal. . .

When we stay "standard of care" the standard of care in a public health setting [it] is not the standard of care you would find in perio in a general office. . . The tools that you use are different, The theories are . . . philosophically different. . . the concepts of public health are different and they are a specialty.

(Tr. P. 156-158).

In the public health setting, the standard of care permits the dental provider to "accept [for sealing] something that is more incipient or wider or bigger because that's better than nothing." (Tr. P. 168). "[W]e're more likely to seal something they might not in private [practice] because of . . . the factors . . . variables that we have to deal with." (Tr. P. 170).

In assessing how to proceed and whether to seal a tooth in a public health school setting,

You really have very little control over whether you're going to see the patient again or not. . . perhaps . . . [you] have to assume that if you're seeing a child for the first time at the dentist and they are 12, 13, 14 years old, you have to assume that the likelihood of them following through on your advice. . . is small. And in that case, [the hygienist] has to make some difficult and different decisions than a dentist would in private practice.

(Tr. P. 195).

Dr. Richard Simonsen, probably the most published scholar on the issue of dental sealants and school-based dental health programs⁶, testified as an expert in the field of dentistry, particularly with an expertise in sealants and cariology⁷. (Tr. P. 179). Dr. Simonsen serves as the expert for the Center for Disease Control on school-based sealants projects. He explained the purpose of the school-based sealant programs is to "designed to introduce children to preventative dentistry and to get them understanding, and their parents understanding, that they need to continue dental care throughout life and, if they have problems, to visit the dentist." (Tr. P. 179).

⁶ Dr. Simonsen has studied sealants since 1973, when he was mentored by Dr. Leon Silvertone, who was then the world's expert on the issue dental bonding and sealants. (Tr. P. 178). Dr. Simonsen had started to use sealants in the clinical setting in Norway, before moving to the United States, but he began his research and clinical trials in 1973. *Id.* He published his first article on sealants in 1977, and continued to publish on the issue. His seminal publication was a 15-year study on sealants that was published in the Journal of the American Dental Association in 1991. He also published a review of the literature (approximately 800 articles) on the subject in 2002, and most recently published an article on the subject in the Dental Clinics of North America.

⁷ As indicated earlier, the South Carolina program is based, at least in part, on recommendations of the CDC, and the South Carolina program is anticipating updated information and protocols for its protocols. (See p.5, *supra*).

In understanding the use of sealants in any dental setting, it is important to note the difficulty clinicians have in diagnosing caries in the first place. Dr. Simonsen, who has done post-graduate work in cariology, explained that

It became very clear that not only . . . are the multifactorial causes of dental caries difficult to detect sometimes, but also it's very difficult for an individual clinician to diagnose caries. . . It's . . . a very difficult disease to definitively detect and it requires multiple bits of information.

(Tr. P. 183).

Dr. Simonsen provided examples of the difficulty in diagnosing caries using the visual and tactile senses by using a series of slides showing what appear to be carious lesions that turned out to have no caries present. (Tr. P. 183-184). He concluded:

We have to admit it, that we are guessing when it comes to diagnosing the carious status of pits and fissures. We do our best based on our clinical experience and the knowledge that we've learned and the examination of a particular site at a particular time, and come to a professional judgment; but that's what it is, a judgment. . .

(Tr. P. 184).

Dr. Simonsen acknowledged that one factor in determining how to treat a tooth with possible caries is the likelihood that the patient is likely to obtain dental care. (Id). With that in mind, "the question before us really is can I seal over a small carious lesion or should I remove the caries." (Tr. P. 186). Clearly, in the school-based program, the hygienists don't have the option of removing the caries. So, when in doubt, after cleaning, they seal, even if there is a suspicion of caries on the tooth.

The next question, then, is whether the placement of sealants on teeth that may have caries provides good dental care to the patients. It is clear that sealants, properly applied, cut off the flow of oxygen to the site and, if there is caries present, the growth of the caries is arrested. (Tr. pp. 230-231). Studies from Stanley Handleman and Ron Jordan, as far back as 1976, have

addressed the development of caries in teeth that have been sealed with the caries in place.

These studies have demonstrated that, not only is no harm done from the placement of the sealants, the sealants can arrest the growth of caries, thereby benefiting the patient, especially if no follow-up dental care is received. (Tr. P. 187-188)⁸. Thus, the undisputed conclusion is:

If the lesion is sealed off [using sealants], a successful seal will not allow the bacteria to remain in that lesion to produce acid because they're cut off from the source of nutrition and the lesion will stop progressing. It will not necessarily remineralize or heal itself, but it will stop progressing

(Tr. P. 189)⁹.

There is also research that the placement of a sealant on a caries lesion does not cause any harm to the tooth. (Tr. P. 191). The usual susceptibility to decay is not altered by having a sealant placed on the tooth. *Id.* It is absolutely untrue, as argued by at least one of the state's witnesses, that sealants promote decay. "Even if it is placed, and partially lost, it will not create harm." (Tr. P. 192). Thus, when faced with possible caries on a tooth on a student, in a public health setting, who may or may not receive follow-up dental care, the standard of care is to place a sealant on the tooth. (Tr. P. 194-195). If the student receives no follow-up care, the growth carious lesion may have been arrested. Even if the seal is not properly applied and is partially lost, the sealant which remains provides some level of protection against the development of pit and fissure caries. If the student subsequently goes to a dentist and it is determined that there is caries on the tooth which requires restoration, the sealant is easily removed from the tooth without harm or pain to the patient.

⁸ A study by Eva Mertz-Fairhurst at the Medical College of Georgia concluded that "bonded and sealed composite restorations placed over the frank cavitated lesions arrested the clinical progress of these lesions." *Id.* Thus, properly placed sealants have the same clinical benefits as bonded and sealed restorations when cavitation is not removed prior to sealing. *Id.*

⁹ Dr. Simonsen's 15-year study used a control group of unsealed patients and a group of patients whose teeth had been sealed. "It was done in a matched pair analysis. . . not only did the control, which did not get sealant, have restorations but that at 15 years a cusp was fractured. So, this is really the restoration and re-restoration cycle that you get with . . . routine restorative dentistry, as opposed to trying to prevent the restorations in the first place." (Tr. P. 191).

With disciplinary proceedings having been brought as a result of the placement of sealants in the public health setting,

We have hygienists who are scared to place sealants. And to me, that's a tragedy. It's a tragedy of our profession. Sealants should be much more widely used, they're clearly beneficial . . .

(Tr. P. 193).

A dental hygienist in the public health setting has to gauge several factors, "and if the judgment is that the likelihood of them going to dentist is small, then I think the natural and only decision is you seal the tooth. . . you're obligated, I believe, to do whatever you can to slow the progress of the disease." (Tr. P. 196).

The issues before the Board in these cases include allegations that certain of the respondents placed dental sealants over "gross decay" or "gross caries." While it is not possible to seal over gross decay that manifests itself in soft decayed dentin, it is possible to seal over gross decay that is underneath enamel. "It's perfectly easy to seal even large hidden carious lesions, and . . . it is in the best interests of the patient to do that if . . . you judge that it is unlikely that the child will go for further dental care¹⁰." (Tr. P. 198). "In the situation of trying to reduce risk to a child, . . . it's good policy to seal caries where the other alternatives options of the child are minimal." (Tr. P. 199).

Ironically, the United States lags behind other countries in recognizing the benefits of sealants. Sealants are much more widely used in Europe and particularly Finland, where Dr. Sorensen estimates that 85 percent 85 percent of all 12-year olds have sealants on their teeth,

¹⁰ In the private practice setting, however, the standard of care is different. "The reason we don't recommend in normal private practice to seal carious lesions is that over time sealants wear down, and so there will come a time when a carious lesion that has been sealed could become active again as the sealant wears down to a point where the fissure connection with the oral fluids is once again found. So, that is why in the ideal situation, we don't do it." (Tr. P. 199).

largely through school-based public health programs. (Tr. P. 200). Denmark, in fact, has a standard of care which specifically includes applying sealants on incipient lesions. (Tr. p. 201). Scandinavian counties are much more advanced in terms of caries research than the United States and other countries. *Id.*

**DUE PROCESS REQUIRES THAT THE DENTAL BOARD
SHOULD NOT ADJUDICATE THESE CASES**

The record establishes that sealants have tremendous benefit, little (if any) risk, minimal cost, are not invasive, are pain-free and, if subsequent dental care is obtained and lesions which require restoration are found, the sealants are easily removed. Why would the standard of care not include widespread use of sealants (in public health programs and otherwise), if the incidence of caries can be reduced, even minimally.

The only possible answer, unfortunately, is that caries-free teeth, or reduced incidence of caries, are not economically beneficial to the private practice of dentistry, where providers can recover larger revenues from restorative dentistry than they can from preventative care.

With this premise, it is clear that allowing the Dental Board to police the conduct of dental hygienists in the public health setting is akin to allowing the fox to guard the henhouse. Particularly here, where the Dental Board has demonstrated a virtually unending hostility to the school-based program¹¹, it cannot possibly afford due process to the dental hygienists to have their licensing, and discipline, in the hands of a regulatory agency whose Board members have an economic interest in shutting down the school-based hygienists program. Moreover, the

¹¹ For a brief history of the Dental Board's efforts to prevent the establishment and operation of the school-based program, see *In the Matter of the South Carolina State Board of Dentistry*, FTC Docket No. 9311 (September 15, 2003). The Federal Trade Commission has charged the Dental Board with violations of the federal antitrust laws as a result of the Board's vigorous efforts to shut down the dental hygienist program. The South Carolina Administrative Law Court has also had to deal with overreaching by the Dental Board in its efforts to shut down the school based hygienist program. *Health Promotion Specialists LLC v. South Carolina Board of Dentistry*, Case No. 2001-CP-40-3148.

actions of the Board have historically demonstrated an active bias toward the school based dental health program as well as efforts to shut it down. (Exhibit A)

Due Process, under both the federal and state constitutions, requires that persons who have knowledge of, or formed an opinion about, the issues in an administrative adjudicative function, "distance themselves from the adjudicatory process" and not participate in any fashion in the proceedings. *Garris v. Governing Board of the South Carolina Reinsurance Facility*, 333 S.C. 432, 511 S.E.2d 48 (1998). Unfortunately, here, members of the hearing panel and of the Dental Board, are members of the South Carolina Dental Association, which has paid lobbyists for years to defeat the school-based program and whose literature demonstrates a clear bias against the hygienists working in schools.

Respondents are aware that it is necessary to show actual bias rather than mere potential for bias in order to show a due process violation. *Kizer v. Dorchester County Vocational Educational Board of Trustees*, 287 S.C. 545, 340 S.E.2d 144 (1986). For that reason, in order to explore these issues and present a sufficient record for appellate review, respondent requests that the Board convene a hearing for the purpose of taking testimony regarding the activities of the Board, the South Carolina Dental Association, and/or members of the Board and/or the hearing panel, relative to the emergency regulation enacted in 2001, and other the efforts by the Board and persons associated with it to sabotage the school-based dental health program generally. The hearing should further explore the history of litigation between the Board, the respondent's employer and the Dental Association¹².

Respondents assert that it is impossible for an appellate court to adequately address the issues of bias which are critical to the respondents' due process concerns without an evidentiary

¹² Respondents would also renew their request for a copy of the actual complaints which were filed against them in these proceedings, because the source and content of those complaints are relevant to the issues of bias.

record sufficient to address these issues¹³. Respondents are entitled to explore issues of bias in the context of these disciplinary proceedings, and to present a sufficient record to the appellate courts for these issues to be addressed.

In the alternative, respondents assert that the Dental Board should voluntarily recuse or disqualify itself from adjudicating these disciplinary proceedings, and should certify these cases to be heard as contested cases before the Administrative Law Court. In that manner, these matters can be adjudicated fairly, without a detailed evaluation of the Board's actual bias toward respondents, their employer, and the school-based dental care program generally, as well as specific inquiry into the financial incentives of the Board and its membership to eliminating the school-based program.

RESERVATION OF RIGHTS

Respondents specifically reserve the right to dispute the report and recommendations of the hearing panel, to submit argument, memoranda and authorities in support of their position on the merits of these disciplinary proceedings, and to otherwise address respondents' legal rights in these proceedings.

WHEREFORE, for the reasons set forth above, respondents move for an order:

- A. Disqualifying the Board from adjudicating these proceedings; or
- B. Empanelling an evidentiary hearing on issues related to actual bias of the Board, its members, and/or its agents, relative to the due process rights of the respondents herein; and

¹³ On appeal from this Board, the Administrative Law Court may require the taking of additional testimony on material issues that are not fully documented in the record. S. C. Code Ann. Section 1-23-380(A)(4). It is respondents' position that this evidentiary matter should be included during the Board proceedings.

- C. Setting forth the standard of care applicable to dental hygienists working in the public health setting, which will set a threshold against which the merits of the instant cases can be determined.

Respectfully submitted,



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ATTORNEY FOR RESPONDENTS

West Columbia, South Carolina
March 22, 2006

Executive Director's NOTES

Whether she means to do it or not the name of Tammi Byrd will become well known in South Carolina dental circles. The truth of the matter is, only she holds the key as to whether the connection with her name is positive or negative.

Ms. Byrd has started a company and hired a staff - including, I am told, a dentist - to go into schools in as many as 15 counties where the school children on free or reduced lunch programs account for the highest percent. She and her team will conduct screenings for which there is no reimbursement that I know of and perform prophys and apply sealants (which, thanks to efforts of the SCDA and a children's coalition pays at the 75th percentile of 1998 UCR's for the state).

First off, I applaud Ms. Byrd for her ingenuity and willingness to get into this fray. There is some talk that the American Dental Hygienists' Association is footing at least a part of the startup cost. Others have said that equipment companies are helping. Other speculation is that one or more dentists are backing the effort.

The bottom line is, it doesn't matter. There are thousands of students in South Carolina's public schools who do not have access to dental care. This is not because the dentists, hygienists, and assistants of the dental team are not interested in their needs. It can be something as simple as the parents not placing any emphasis whatsoever on the oral needs of their children.

I have been told of one child in Allendale County who needed a root canal. The mother did not bring the child to two scheduled appointments in a row and then showed up and demanded that the tooth be pulled "because she was sick and tired of hearing the child whine and complain." My first thought was to ask why the problem couldn't have been inspected on the mother, and then step back and see how long it took her to seek help. But that's another story.

Ms. Byrd and her staff apparently are seeking - or maybe already have - a

contract to follow up on children who do not show up for dental appointments under the Medicaid program. It is truly hoped that their efforts will be successful.

Hygienists in South Carolina - of which Ms. Byrd is one - can't work in school and institutional settings under general supervision. They have been able to do so since May of 1988. However, they sought clarification of that portion of the code in 2006 and have themselves interpreted that revised law as allowing hygienists to be paid directly by Medicaid for work performed under general supervision.

Believe me, that is not the same interpretation the SCDA has backed up by its attorney. In fact, the SCDA Board took definitive action at its meeting Oct. 27th. Based on its attorney's guidance, the Board has directed President Charles Millswood and myself to seek an immediate injunction should the S.C. Department of Health and Human Services - or any other agency for that matter - attempt to pay a hygienist directly for work performed under general supervision.

Hopefully, none of this action will be necessary. Ms. Byrd and her company would probably best align themselves with dentists in the communities in which they plan to work. That way, they have a dentist to whom they can refer patients for restorative treatment - and there will be many of these.

A word of caution. Because the hygienists are working under general supervision, there must be a dentist who is legally liable for all actions. Ms. Byrd apparently - at least initially - has her own interpretation of the law in that she apparently thought she could hire one dentist to sit in one locale and sign off on whatever documentation she presented.

According to the President of the State Board of Dentistry, Dr. Ron Barrier, Ms. Byrd's interpretation is not quite on the mark. The State Board has issued an opinion that the dentist in charge must basically write a work order or



Hal Zorn
Executive Director

the name of
Tammi Byrd will
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dental circles

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prescription after seeing the child, for the hygienists to go into the schools and performed the work they say they wish to do.

As long as Ms. Byrd and her company work within the law in South Carolina, it is to the benefit of the children that the dentists of the state work cooperatively to provide the access to care which many thousands of children desperately need by treating children referred to them.

South Carolina has received national recognition for the manner in which it approached the access to dental care crisis beginning in 1999. Let's carry that tradition forward.

Good luck Ms. Byrd. As was promised to you in a meeting five years ago attended by Ms. Beverly Dunbar and your lobbyist at that time, the officers of the SCDA stand ready to talk with you - particularly about anything that will benefit the children of this state. But, you must make an effort toward direct and open communication.

Making an Effort

The SCDA has joined with the nine technical colleges offering dental auxiliary training and is sending to dental labs and dentists two surveys developed by Ms. Alice Derouen of Horry-Georgetown Tech.

The survey to be completed by dentists is enclosed in this issue of The Bulletin. The dental lab's survey has been mailed directly to the labs. Ms. Derouen has agreed to tabulate the results of the survey, and is to share the information with the faculty members and health deans of the other eight colleges.

Representatives from the nine colleges will present their evaluation at the semi-annual Education Task Force meeting which is to be held March 2, 2001, at the SCDA office.

The purpose of the surveys is to help the technical colleges determine the degree of need for one or more dental lab technician training programs here in the state. For more than a decade, the dental lab owners have forecast the impending shortage of dental lab technicians. However, while there have been several efforts to implement a training program, the low starting salary for potential graduates has been a major drawback to implementation.

I appreciate very much Ms. Derouen's efforts to gather the information which will be needed for this thorough evaluation.

At the March 2nd meeting, the Education Task Force is returning somewhat to its original roots of a dozen years ago. For the first time in many years, the State Board of Dentistry and a representative of MUSC's college of Dental Medicine have been invited to attend and participate.

Leadership Now!

ADA 16th District Trustee Carroll Player and former 16th District Trustee Greg Chadwick, who is now ADA president elect, have a unique opportunity to set the trend in organized dentistry for the next decade. They both will play key roles in the hiring of a new executive director for the ADA.

Current ADA Executive Director John Zappi announced his retirement as of the end of March 2001 during the just

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concluded ADA House of Delegates meeting in Chicago.

I personally hope the ADA Board will use this change to open a positive era of working relationships between the ADA and its constituent and component societies. An almost adversarial mill has developed that is not conducive to growth within organized dentistry.

We must find ways to recognize and foster the strengths of each level of the tripartite system. An idea I heard in Chicago which has merit is the new administration needs a deputy executive director assigned to foster good relations between the tripartite system. I believe this is realistic. I don't want to see the ADA follow in the footsteps of some other previously strong health related associations.

The leadership of the ADA has a unique and responsible decision to make, and I am glad that Doctors Chadwick and Player are a part of the team.

THE MEANING OF LICENSURE

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demonstrate a minimum of 5,000 hours of active clinical practice in the past seven years.

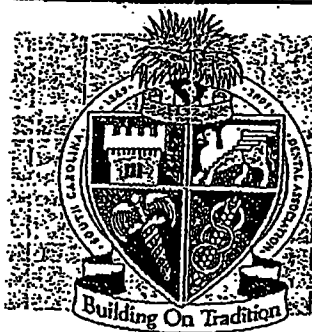
Three states, Georgia, South Carolina, and Wyoming whose dental boards have the statutory authority to implement licensure recognition to licensed applicants from other states have either not adopted rules to implement a license recognition system, or have suspended the practice.

A more restrictive type of licensure by credentials, licensure "by reciprocity", refers to a jurisdiction's authority to grant licensure recognition ONLY to licensees of states that grant reciprocal recognition to licensees from the receiving jurisdiction. Such decisions may be based on agreements between state boards. There are seven states that limit the credentialing process to reciprocal states.

The ADA currently recognizes nine dental specialties: dental public health; endodontics; oral and maxillofacial pathology; oral and maxillofacial radiology; oral and maxillofacial surgery; orthodontics and dentofacial orthopedics; pediatric dentistry; periodontics; and prosthodontics. ADA policy, as well as many state dental practice acts, provides specific direction for the announcement of both general and specialty practice credentials. Sixteen states require specialists to obtain a special license in order to announce themselves as specialists, or to announce a limitation of practice in a recognized specialty. All states that license dental specialists require the dentist to have a general dentistry license from their state, with the exception of Idaho and Oregon, where a license from any state qualifies.

Where states require the licensing of dental specialties ADA policy encourages constituent societies and state boards of dentistry to implement specialty licensure by credential.

SCDA Bulletin December 2000



President's MESSAGE

Recently, the SCDA had a meeting with Ms. Tammi Byrd in an attempt to learn about the plans for her new company, Health Promotion Specialists. Also present were members of the SCDA Executive Committee, our attorney, lobbyist, Executive Director, and the entire state Board of Dentistry. Ms. Byrd intends to go into school districts with high numbers of students on free or reduced-lunch programs. This targets Medicaid eligible children. Using portable dental equipment she and her hygiene staff will perform screenings, prophyls, and apply fluoride and sealants. After obtaining parental permission, she had hoped to work under the general supervision of a dentist who would never examine a single patient. Ms. Byrd attempted to recruit several dentists with this "non-responsibility" as an enticement. Since Medicaid will not reimburse a hygienist directly, Ms. Byrd's company must employ a dentist in order to obtain a provider number. During our meeting it was established that the only way this company could legally operate was for a dentist to examine each prospective patient and authorize the procedures to be performed.

The Florida Attorney General's office recently broke up an operation that was using vans traveling the state performing questionable treatments and bilking Medicaid. The number of arrests was high, and it has been reported that this operation has moved into South Carolina. We cannot allow fuzzy schemes as a means to treat Medicaid patients in our state. It has been reported that Ms. Byrd has recruited

dentists who do not have Medicaid provider numbers. One dentist admitted that he was interested in making money, not treating Medicaid children. I question her motives and method of operation. The SCDA would endorse a program with increased access to care if it provided first-rate dental care. But I cannot endorse a program advocating substandard care for the disadvantaged children of South Carolina.

The SCDA is working closely with Dr. Ray LaLa (our new State Dental Health Coordinator), administrators from DHEC, DHHS, and community leaders from the private sector to prepare for the upcoming conference, "Improving Oral Health Care for Children". Sponsored by the National Governors' Association, the conference will be held December 13-15, 2000 in Charleston. Our objective is to develop an action plan that can realistically be implemented to improve the oral health of children in South Carolina. The conference should create and reinforce working relationships between the Governor's office, state legislators, program administrators, and stakeholders from the private sector.

It is not by accident that South Carolina was selected as the site for this conference. During the first ten months of the year 2000, the dentists of our state have treated 42,311 unduplicated new Medicaid patients. The quality of care has increased now that adequate reimbursement is received. Together we are building on established traditions to ensure the continued success of this program. We now have 850 providers



Dr. Charlie Millwood
President

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HERBAL DRUG INTERACTIONS...

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the antiretroviral drug indinavir. Also, some patients may experience increased photosensitivity when St. John's wort and tetracycline are combined, they write. Patients taking Kava-Kava and alprazolam may go into comas, they add.

The first step in preventing any adverse drug reactions is to identify which conventional and/or natural therapies the patient is using, according to Cohan and Jacobsen. Many patients don't inform their dentist or physician that they take alternative products. So the practitioner should create a nonjudgmental office environment and a health history form to ensure that vital information about the patient's use of complementary drugs and other treatment modality is elicited.

the authors continue. They point out that patients are more likely to cooperate if the dentist is able to discuss why that information is relevant to being able to deliver safe and efficacious dental care.

When appropriate, the authors recommend that precautions be taken, such as medical consultations and blood coagulation studies. Finally, Cohan and Jacobsen say it is imperative to advise patients regarding discontinuation of herbal supplements, especially if any moderate to major adverse drug reactions with any drugs the dentist plans to prescribe are established, probable, or suspected.

PRESIDENT'S MESSAGE

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and 27 million dollars has been spent for the treatment of these children. By the end of the year, the program is expected to cost 52 million dollars.

Just a reminder for everyone—as of January 1, 2001 Medicaid claims must be submitted on the new ADA CDT 3 claim form (this is the ADA 1999 version 2000 form listed on page 97 of the CDT 3 manual). You can continue to use the codes listed in the Medicaid Provider Manual. There is a window of several months where CDT 2 and CDT 3 codes can be used. But, don't use both or you will create a Medicaid nightmare of paperwork. It would be simpler to plan on switching to the CDT 3 as of January 1st.

The Ad Hoc Committee on Medicaid chaired by Dr. Lee Gardner continues to assist DHHS with improvements in the system. Call us with your problems and suggestions. We encourage all of you to become a Medicaid provider and help us treat these kids.

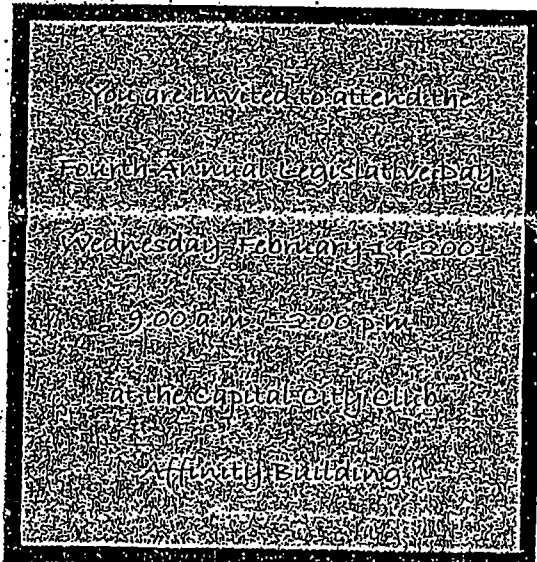
The state of South Carolina is facing a tighter economic year in 2001. All state agencies have been asked to cut their operating budgets by 10-15%. These cuts may jeopardize two projects supported by the SCDA, the Medicaid Program and the new James B. Edwards College of Dental Medicine Clinical facility. Our annual Legislative Day is now more important than ever!! Please plan to meet your legislator at the Capital City Club in Columbia on February 14, 2001. The program will begin at 9:30 AM with an informative program planned by Lobbyist Richard Davis.

Several years ago I made a terrible mistake on my health care coverage. A personal friend in the insurance business convinced me that he could beat the rate for my coverage compared to the SCDA rate. Initially, my premiums were cheaper, but then disaster struck—I was diagnosed with melanoma. Fortunately, I was able to have it surgically removed and have been closely monitored since then. Unfortunately, my "cheaper" insurance premiums skyrocketed after this diagnosis. With "cancer" on my medical history, I could not change carriers. The SCDA offered an open enrollment with PHP and I was able to obtain coverage. My

advice to the young dentists is not to make the same mistake I made. You need the strength of the SCDA group plan.

Do you know of someone who has achieved special recognition or performed an outstanding service in the dental profession? The 2001 Awards Program Nomination Form was enclosed in the last bulletin. The deadline for returning nominations to the SCDA office is January 8, 2001.

At this very special time of the year, let each of us pause and give thanks for the many blessings in our lives. Make time for your families and tell them how important they are to you. Let your staff know how much you appreciate all they do for your practice. I wish each of you a blessed and joyous holiday season.



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BOBBY E. McBRIDE, DDS.

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Executive Director's NOTES

Several complaints have been lodged against dentists who have followed directions from the SCDA and S.C. Department of Health and Human Services (DHHS) that Medicaid patients be treated exactly like paying patients.

The rub comes when dentists charge Medicaid patients for broken appointments, just as they do for paying patients. Our attorneys have researched the issue and talked with officials on the state and federal level.

There is no law which states directly that a patient cannot be charged by a dentist for a no show. However, there is a policy within the federal Health Care Finance Agency (HCFA) that would preclude this from being legal.

Based on research and advice from Mr. Brad Willbanks, one of the SCDA lawyers, the SCDA has asked ADA President-Elect Greg Chadwick for the ADA's help in getting an exception to this policy for dentists. Mr. Willbanks' research indicated there was at least a small degree of probability that HCFA would at least look at such an exemption.

In the meantime, it is legal for you to have a written policy as outlined in the manual provided in 1999 where you notify patients up front - both paying and Medicaid - that broken appointments will result in the patients no longer being treated by the practice.

Please us this method and together with the ADA, the SCDA will work to get this HCFA policy changed.

Changing Things

Things are a changing. South Carolina has the premier dental Medicaid program in the United States, but we are mired today in what may very well appear to the public to be a turf battle with a small group of hygienists.

The truth is "the market" - and it should be inconceivable for me to call our children a market - is much bigger than all of us combined will probably be in a position to adequately treat. So what are the seemingly insurmountable problems that we must find solutions to? The first problem is how we reach beyond the animosity that has grown up over the years between several key members of the S.C. Dental Hygienists Association and key members of the S.C. Dental Association.

If it is simply a matter of money and power, I doubt if this schism can be breached. If there truly is a desire on everyone's part to build a workable, permanent solution to the access to care crisis which continues in South Carolina, perhaps we can find our way to the conference table and work on this basic problem.

The SCDA has worked for years within its own ranks to block other dentists who would "milk" the Medicaid system of the "easy" money and leave the problem restorations to the relatively few pedodontists in this state. In addition, in developing the new dental Medicaid program, the SCDA has encouraged general dentists in this state to treat children eight years old and above.

What other problems exist as a block to working jointly on the access to dental care problem? Are the children receiving comprehensive dental care? Ms. Tammi Byrd of Health Promotion Specialists was quoted in the Camden Chronicle-Independent newspaper as stating her team of hygienists and dentists are now in 26 school districts in the state. That is more than a fourth of the total school districts.

In addition, this newspaper article related that Ms. Byrd has stated her team

(Continued on page 8)



Hal Zorn
Executive Director

*It should be
inconceivable for me to
call our children a
market.*

(continued from page 7)

has screened more than 15,000 children since January 1, 2001. That's absolutely and truly great. More power to her and her fellow workers -- both hygienists and dentists.

But, where does the comprehensive care come in? Ms. Byrd, in the Camden newspaper article noted that more than 33 percent of the children screened have obvious dental problems which need attention. "Our No. 1 goal is to get these kids into a dentist's office in the area. We work with the parents to try to set up a dental appointment," Ms. Byrd was quoted as stating.

Yet, later in the article, Ms. Byrd is quoted as saying, "It's something new. It's just hard to change sometimes. HPS presented this program several months ago. The dentists found out about it and felt threatened." She said referrals to local dentists are the goal for HPS.

This is basically one of the two core problems in what should be a workable relationship. Ms. Byrd apparently does not ask to meet with local dentists when she starts to move into a new school district. She apparently does not have a base of dentists to which she can refer the 33 percent of children screened who have obvious dental problems.

The second problem which must be addressed, in my opinion, is Ms. Byrd's team performing prophylaxis and placing sealants on the teeth of children who are patients of record, thus creating a

situation in which DHHS is currently spending twice the money on Medicaid eligible children. DHHS cannot keep up that practice and the SCDA is working with DHHS to find a solution without jeopardizing the comprehensive care these 33 percent of children screened need.

Ms. Byrd was quoted as using the term "threatened". I have found that the ultimate group that is threatened is the children. Why can't the adults get together and work on a solution for the children? Therein, everyone will benefit.

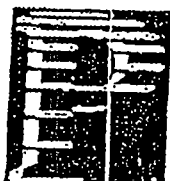
From the corner of my brain comes a recurring question: "Haven't we tried?" The answer is yes from the SCDA standpoint. But the facts are no one has succeeded.

In the meantime, our own SCDA members want to know, "What has the SCDA done for us lately specifically dealing with this subject?" The principle thing is the SCDA will mail to every school superintendent, school board member and school nurse an informational letter signed by a coalition of children's advocates spelling out the position of the SCDA on this subject. It too is a positive move to get a direct dialogue going to benefit the children.

Herrington On The Move

Another example of change being inevitable is an

(continued on page 10)



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**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND
REGULATION
BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY**

In the Matter of:

[REDACTED] R.D.H.

License No. [REDACTED]

No. 04-67

Respondent.

In the Matter of:

[REDACTED] R.D.H.,

License No. [REDACTED]

Nos. 02-98, 02-99, 03-20

Respondent.

In the Matter of:

[REDACTED] R.D.H.

License No. [REDACTED]

No. 04-45

Respondent.

In the Matter of:

[REDACTED] R.D.H.

License No. [REDACTED]

No. 03-104

Respondent.

**MEMORANDUM IN
RESPONSE TO
RESPONDENTS'
MEMORANDUM AND MOTION
FILED ON MARCH 22, 2006**

STATEMENT

The above matters consist of several cases that were tried before the same hearing panel on December 2 and 3, 2006. Each case involved allegations that the Respondents had violated the applicable standard of care by applying sealants to teeth when decay on the sealed teeth should have been obvious to the examining hygienist. It was stipulated that the evidence introduced in connection with any one of the four Respondents could be incorporated by reference as part of the case involving any other of the four Respondents.

In all, the panel heard evidence involving the treatment of a total of six patients by the four named Respondents.¹ The panel recommended that the charges relating to four of the six patients be dismissed. The panel concluded that in those cases, the evidence did not indicate that those hygienists should have been aware that clinically obvious decay was present. In the other two cases, the panel concluded that the decay was sufficiently obvious that sealants should not have been applied, and recommended discipline as set forth below. The panel's specific recommendations in each case were as follows:

Case No.	Respondent	Patient	Panel Recommendation
04-67	[REDACTED]	K.W.	Dismissal—no violation
02-98	[REDACTED]	F.B.	Dismissal—no violation
03-20	[REDACTED]	B.W.	Dismissal—no violation
04-45	[REDACTED]	T.M.	Dismissal—no violation
04-45	[REDACTED]	M.A.	Violation of standard of care—public reprimand
03-104	[REDACTED]	Q.G.	Violation of standard of care—public reprimand and \$500 fine

¹ Part of the case numbered 02-98 and 02-99, in which [REDACTED] was the Respondent, was withdrawn by LLR counsel at the hearing. 12/3/05 Tr., p. 8. That part of the case related to a patient whose initials were M.K.H.

These cases are presently scheduled for Final Order hearings before the full Board of Dentistry on April 29, 2006.

Counsel for the Respondents has filed a Memorandum and Motion that argues essentially two points. The first point, set forth at pp. 3-10, consists of an argument about the merits of the cases. Since it appears that Respondents' counsel has reserved the right to file additional arguments about the merits of the cases, LLR counsel would in turn reserve the right to address the issues raised on pp. 3-10 of Respondents' Memorandum at such time as LLR counsel addresses the merits in a pre-hearing brief. For the time being, LLR counsel would simply point out that by the great weight of the evidence, including among other things the DHEC guidelines cited on page 4 of the Panel Report in the [REDACTED] case, the standard of care is that sealants should not be placed over readily apparent gross tooth decay. Respondents appear to be arguing that sealants are always appropriate, even when gross decay is obvious to the examining hygienist. LLR would submit that the Board should not adopt such an extreme standard, and reserves the right to argue this issue more fully in a subsequent filing. The remainder of the present Memorandum addresses the issue of what actions, if any, the Board should take either at the Final Order hearing, or prior thereto, with respect to Respondents' claims of bias set forth in Respondents' Motion to Disqualify and/or for Evidentiary Hearing.

ARGUMENT

**Respondents' Motion Should Denied, Because
Respondents Have Not Made Even A Prima Facie
Showing Of Bias By Board Members.**

Respondent has made charges against the Board of Dentistry that are not only outrageous, but also unsupported by any evidence. Respondents, or their counsel, claim that persons engaged in the private practice of dentistry would suppress the use of

preventive care by hygienists because "caries-free teeth, or reduced incidence of caries, are not economically beneficial to the private practice of dentistry. . . ." Respondents' Memorandum at p. 10.

In *Kizer v. Dorchester County Vocational Educ. Bd. of Trustees*, 287 S.C. 545, 340 S.E.2d 144 (1986), the Supreme Court of South Carolina held that school board members, and presumably other administrative tribunals,

are clothed with a presumption of honesty and integrity in the discharge of their decision-making responsibilities. [Citations omitted] In order to disqualify a hearing tribunal, actual bias rather than a mere potential for bias must be shown. [Citations omitted] Individual decision makers must not have exhibited bias as to the factual questions to be decided at hearing, and evidence of actual bias which offends due process consists of statements on the merits by those who must make factual determinations on contested fact issues where fact finding is critical. [Citations omitted] It is not actual bias to have made statements as to policy issues related to a dispute. . . .

287 S.C. at 552, 340 S.E.2d at 148. The allegations of the Respondents are several steps removed from amounting to even a prima facie showing of possible bias. First, Respondents' allegations are not statements of fact, but rather are simply broad, conclusory argumentative statements. The Court of Appeals has held that "It is not enough for a party to allege bias; a party seeking disqualification of a judge must show some evidence of bias or prejudice." *Reading v. Ball*, 291 S.C. 492, 494, 354 S.E.2d 397, 398 (Ct. App. 1987). As stated by the Supreme Court of Alabama, "recusal is not required by a mere accusation of bias unsupported by substantial fact." *Acromag-Viking v. Blalock*, 420 So.2d 60, 61 (Ala. 1982). Respondents have shown no facts, but have only offered unsubstantiated arguments in support of their claims.

Even taking Respondents' conclusory allegations as something more entitled to weight than they are, they still do not establish the necessary elements for disqualification. First, the allegations would appear to relate to statements concerning policy issues, which were held in *Kizer, supra*, not to be proper subjects of a motion to recuse. Secondly, Respondents' allegations about general policy have no relation to the issues in these cases, which as *Kizer* held, are "factual determinations on contested fact issues where fact finding is critical." Nor would Respondents' allegations even remotely suggest that any member of the current Dental Board might be inclined to reach predetermined conclusions about the facts of these cases.

In addition, Respondents fail to note that the membership of the Dental Board in 2001, when certain actions were taken of which Respondents complain, is not the same as it is at present. As shown by the attachment, and as the Board is of course aware, only two dentists and the one public member now on the nine-person Board were members of the Board in 2001. Those individuals are Dr. Bragdon, Dr. Bedell, and Ms. Duncan.

Finally, Respondents argue that they should be permitted an opportunity for a hearing, presumably to see whether they can discover any evidence to support their unsubstantiated claim that there were "efforts by the Board and persons associated with it to sabotage the school-based dental health program generally." Respondents' Memorandum at p. 11. In essence, Respondents seek a hearing that will serve as a discovery device. A similar claim of a need for discovery was made in *Louisiana State Bd. of Medical Examiners v. Golden*, 645 So.2d 690 (La.App. 1994). That court held:

There is no authorization for general discovery proceedings to determine if ground for recusation exist. The party must "discover" the grounds on his own under either provision and then state them with particularity in writing . . . before

a recusal hearing is warranted. It would not be sufficient just to allege general bias against a party or an issue. Some particular fact must be alleged that if proven would support a finding of bias."

645 So.2d at 691. LLR counsel would submit that the same reasoning should apply here. The events of which Respondents complain took place some years ago. Absent a much more compelling showing than has been made here, Respondents should not be permitted an extraordinary hearing with respect to unsupported allegations.²

Counsel would point out, however, that the Board members might wish to make a statement on the record at the Final Order hearing about whether they have made any statements relative to the issues in these cases that would prevent them from providing a fair and impartial hearing. However, whether such an opportunity for statements by Board members should be afforded is an issue to be determined by the Board.

CONCLUSION

For the foregoing reasons, LLR counsel submits that Respondents' Motion to Disqualify and/or For Evidentiary Hearing should be denied, and the cases heard as scheduled on April 29, 2006.

Respectfully submitted,

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION

LYNNE W. ROGERS
General Counsel
Post Office Box 11329 Columbia,
South Carolina 29211-1329
(803) 896-4470

² LLR counsel would also submit that Respondents' request for copies of the initial complaints be denied, based on the confidentiality requirements of the Dental Practice Act, including §§40-15-180 and 40-15-215.

March 28, 2006

BY: Kenneth P. Woodington

KENNETH P. WOODINGTON
DAVIDSON, MORRISON AND
LINDEMANN, P.A.

1611 Devonshire Drive, 2nd Floor
Post Office Box 856
Columbia, South Carolina 29202
(803) 806-8222

ATTORNEYS for the South Carolina
Department of Labor, Licensing and
Regulation

**Board of Dentistry
Members**

William H. Bragdon , DMD

Board Position: President
Statutory Designation: Dentist
Term Appoint Date: 6/1/2000
Term Expire Date: 12/31/2006
City, State: Greenville, SC
District: 4

Present

William Davie Cranford, Jr. , DMD

Board Position: Vice President
Statutory Designation: Dentist
Term Appoint Date: 12/31/2001
Term Expire Date: 12/31/2007
City, State: Rock Hill, SC
District: 5

Present

C. Timothy Assey , DMD

Board Position: Member
Statutory Designation: Dentist
Term Appoint Date: 8/12/2003
Term Expire Date: 12/31/2009
City, State: Mt. Pleasant, SC
District: 1

Present

Michelle D. Bedell , DMD

Board Position: Member
Statutory Designation: Dentist
Term Appoint Date: 11/7/2000
Term Expire Date: 12/31/2006
City, State: Blacksburg, SC
District: N/A

Present

Thomas M. Dixon , DMD

Board Position: Member
Statutory Designation: Dentist
Term Appoint Date: 4/22/2005
Term Expire Date: 12/31/2011
City, State: Honea Path, SC
District: 3

Present

Genie M. Duncan

Board Position: Member
Statutory Designation: Public Member
Term Appoint Date: 9/18/2000
Term Expire Date: 12/31/2006
City, State: West Columbia, SC
District: N/A

Present

Charles E. Millwood, Jr. , DMD

Board Position: Member
Statutory Designation: Dentist
Term Appoint Date: 6/10/2004
Term Expire Date: 12/31/2010
City, State: Cayce, SC
District: 2

Present

3/27/2006

Tanya S. Riffe , RDH
Board Position: Member
Statutory Designation: Dental Hygienist
Term Appoint Date: 12/31/2001
Term Expire Date: 12/31/2007
City, State: Ravenel, SC
District: N/A

Present

John D. Snowden, Sr. , DMD
Board Position: Secretary
Statutory Designation: Dentist
Term Appoint Date: 12/31/2002
Term Expire Date: 12/31/2008
City, State: Florence, SC
District: 6

Absent?

3/27/2006

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED], R.D.H.,

License No. [REDACTED]

Respondent.

NOTICE
OF HEARING

TO THE RESPONDENT ABOVE NAMED:

YOU ARE HEREBY NOTIFIED THAT the South Carolina State Board of Dentistry will hold a hearing regarding the charges contained in the Formal Accusations previously served on you. The hearing will be held on Friday, December 2, 2005, at 9:00 A.M., at the Synergy Business Park, Kingstree Building, Conference Room 108*, 110 Centerview Drive, Columbia, South Carolina.

*Room number is subject to change.

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION
STATE BOARD OF DENTISTRY

BY:


H. RION ALVEY
Administrator

October 24th, 2005.

ROA Ct. of Appeals

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED], R.D.H.,

License No. [REDACTED]

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be served the within Notice of Hearing upon the persons hereafter named, by depositing a copy of same in an envelope, securely wrapped in the United States Mail, certified mail, return receipt requested and by regular first class mail, properly addressed to the said persons hereafter named, at the places and addresses stated below, which are the last known addresses for the same:

Creighton B. Coleman, Esquire
Post Office Box 1006
Winnsboro SC 29180

[REDACTED]
[REDACTED]
[REDACTED]

Desa A. Ballard, Esquire
226 State Street
West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT
OF LABOR, LICENSING &
REGULATION

Jennifer E. Cooper
Jennifer E. Cooper, Administrative Assistant
LLR- Office of General Counsel
Post Office Box 11329
Columbia SC 29211 1329

Columbia, South Carolina
October 24, 2005

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED], R.D.H.,

License No. [REDACTED]

Respondent.

NOTICE
OF HEARING

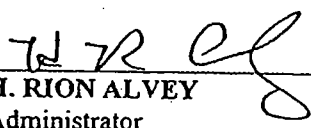
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*Room number is subject to change.

SOUTH CAROLINA DEPARTMENT OF
LABOR, LICENSING & REGULATION
STATE BOARD OF DENTISTRY

BY:


H. RION ALVEY
Administrator

October 24th, 2005.

BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:

[REDACTED], R.D.H.,

License No. [REDACTED]

Respondent.

CERTIFICATE OF SERVICE

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West Columbia, SC 29169

SOUTH CAROLINA DEPARTMENT
OF LABOR, LICENSING &
REGULATION


Jennifer E. Cooper, Administrative Assistant
LLR- Office of General Counsel
Post Office Box 11329
Columbia SC 29211 1329

Columbia, South Carolina
October 27, 2005

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY
Case No. 03-104

IN THE MATTER OF:

██████████, R.D.H.,

License No. ██████████

Respondent.

MEMORANDUM TO BOARD

Respondent ██████████, RDH, objects to the Report and Recommendation in this matter dated February 6, 2006. Respondent's prior motion and memorandum, dated March 22, 2006, is incorporated herein by reference as fully as is repeated herein verbatim. In addition, Respondent would raise the following issues.

ISSUE ONE

The panel erred in finding that Respondent had placed sealants over "clinically obvious decay."

The Panel found that Respondent placed sealant over "clinically obvious decay." Presumably, the panel was referring to tooth #3, which was the tooth about which the testimony was offered (although the Panel's report does not attempt to identify the tooth in question). There is no testimony in the record which describes the decay on tooth #3 was obvious. In fact, Respondent's expert, Dr. Richard Simonsen, examining photos taken by the treating dentist, testified that the visual inspection of the tooth appeared to be incipient decay. (Tr. P. 28, lines 4 - 16). The treating dentist, Dr. Adams, did not describe the decay on #3 as "clinically obvious." Dr. Adams' hygienist noted "rampant decay" in a visit on September 2, 2003, but Dr. Adams himself only planned restorations to teeth #2, 3, and 4 for the next visit. (Petitioner's Ex. 12)¹.

¹ His hygienist had performed a prophylaxis and fluoride on February 27, 2003. Apparently the treating dentist did not do a full examination when he saw the patient on March 3, 2003, when he removed root tips on tooth #1; the

Dr. Adams' diagnosis depended on a physical examination of the teeth, "using my explorer, my sharp explorer² with a light touch, I got a stick. . . just like leather-like, put it in leather and it pulls back and you get a little stick." (Tr. P. 11, lines 3-10). As to tooth #3, he testified that he was able to discern there was likely decay in the tooth using the explorer, and also because on visual inspection because of "a dark halo on the occlusal surface" of the tooth. (Tr. P. 11, lines 3-14)³. Had the decay been "rampant" or "obvious" there would have been little need to probe the tooth with the explorer to make the diagnosis, and the visual diagnosis would have been something more than a "halo" around the tooth.

Attached hereto is Petitioner's Exhibit 13, which shows photos (taken by Dr. Adams) of the tooth #3 (and others), taken after Respondent had placed seals on certain of the teeth, including #3. Using this photo, Dr. Simonsen accurately described the carious lesion on tooth #3 as "incipient." Only after removing the sealant and performing a fissurotomy is decay visible to the naked eye. (Petitioner's Exhibit 13).

A. [by Dr. Adams] . . . So the next photo that I took was the one . . . [that] says 'number 3 after sealant removal and fissurotomy. . . fissurotomy is just removing the enamel that's in the grooves. . . gaining access to the decay.'"

first apparent full examination by Dr. Adams was on September 2, 2003, when the chart was completed. (Petitioner's Ex. 12).

² Interestingly, there is some literature which suggests that probing with a sharp explorer can aggravate non-carious lesions and generate cavitation. "Traditional probing with a sharp explorer has come into question as the ultimate determinant of caries activity. The exclusive use of a "catch" by the sharp explorer to diagnose caries in pit and fissure sites should be discontinued and clinicians are being called to use "sharp eyes and a blunt explorer". Also non-cavitated lesions can become cavitated simply through pressure from the explorer during the typical examination. Thus, penetration by a sharp explorer can actually cause cavitation in areas that are remineralizing or could be remineralized. An explorer can also transfer cariogenic bacteria from one tooth surface to another." (emphasis added) "Treating Caries as an Infectious Disease. JADA 125 (June):2-S to 15-S(1995) citing Elkstrand et al, 1987).

³ That clinical observation is not noted in the records. (Petitioner's Ex. 12).

(Tr. P. 15, lines 5 – 17). Only after performing the fissurotomy was Dr. Adams able to conclude that he “was correct” in his initial thought that decay was present⁴. *Id.*

Dr. Adams described the lesion as “frank” cavitation, which he based upon the visual of the “halo.” (Tr. P. 12, line 21 – p. 13, line 7). This is obviously an overstatement, made to support Dr. Adam’s decision to report Respondent to the licensing board. (Petitioner’s Ex. 12 “. . . wrote & sent complaint letter to the S.C. LLR w/ photos.”).

Interestingly, Dr. Adams claimed to be completely unaware of the considerable research that sealants can help arrest decay.

Q. And you’re familiar with the fact that a properly placed sealant can in fact arrest the development of caries in a tooth if it’s properly placed and if the child doesn’t see a dentist after that, then we’ve accomplished some preventative dentistry for that student, correct?

A. According to Dr. Simonsen, yes.

Q. You disagree with Dr. Simonsen?

A. I don’t have an opinion on that.

(Tr. P. 20, lines 8 – 17).

Q. . . . And you don’t have an opinion as to whether the placement of sealant on incipient or other kinds of caries in fact seals off the nutrients and stops growth of the caries, correct? You don’t have an opinion on that?

A. I have a hard time believing it, but yet I know there are studies on both sides⁵.

⁴ As Dr. Simonsen explained, “we can’t define the actual status of that tooth without extracting it and sectioning it and examining it histologically. . . . I think we have to admit it, that we are guessing when it comes to diagnosing the carious status of pits and fissures. We do our best based on our clinical experience and . . . but that’s what it is, a judgment.” (Tr. P. 183 line 20 – p. 184, line 8).

⁵ Dr. Adams was incorrect, the only studies that address this issue clearly demonstrate that a properly placed sealant can arrest the growth of caries. “There’s also a study out there that talks about sealants not doing any harm,

Tr. P. 22, line 23 – p. 23, line 4).

There is insufficient evidence to support the panel's conclusion that Respondent placed the sealant over "clinically obvious decay" on tooth #3. As is apparent from Dr. Adams' testimony, only by probing the tooth with the explorer was he able to confirm his diagnosis; the only visible clue he described as the "halo" which he observed from visual inspection. Dr. Simonsen described the decay he observed from the photograph as "incipient." While Dr. Adams described it as "frank" cavitation, he acknowledged that the diagnosis was made only after the fissurotomy, when he exposed the carious lesion. No one described the decay as "clinically obvious," and the photographs and testimony clearly refute this description.

The language regarding "clinically obvious" adopted by the panel apparently comes from the diagnosis by Dr. Adams' hygienist of "rampant decay;" however, her "diagnosis" does not relate to tooth #3. It is a general description of the patient's mouth as a whole, and the charges here relate only to Respondent's treatment of tooth #3. We know from the direct evidence that tooth #3 did not have "clinically obvious" decay.

This finding is erroneous.

and the usual susceptibility to decay is not altered by having them treated with a sealant that is not retained." Tr. P. 191, line 22 – p. 192, line 1).

Issue Two

The panel failed to recognize or apply the proper burden of proof in these proceedings. The evidence does not sustain a finding of misconduct by a preponderance of the evidence.

Under South Carolina law, a professional license issued by regulatory authorities is a "property interest" which requires that a disciplinary proceeding afford due process of law before a finding of misconduct can be made or professional discipline imposed. *Zaman v. South Carolina State Board of Medical Examiners*, 305 S.C. 281, 408 W.E.2d 213 (1991). While due process does not require any particular form of procedure, it does require that any misconduct be established by the preponderance of the evidence. *Anonymous v. State Board of Medical Examiners*, 329 S.C. 371, 496 S.E.2d 17 (1998).

Preponderance of the evidence is evidence is the "greater weight of the evidence" and "evidence which convinces" the fact finder "of its truth." *Lee v. Lee*, 237 S.C. 532, 118 S.E.2d 171 (1961); *In re: Marks*, 40 B.R. 614 (Ban.D.S.C. 1984). Findings of fact based on a preponderance of the evidence are "those supported by the greatest weight, amount, credibility or truth, as reflected by the whole of the evidence before the court." *Janasik v. Fairway Oaks Villa Horizontal Property Regime*, 307 S.C. 339, 415 S.E.2d 384 (1992).

What we mean by the greater weight of the evidence can be illustrated by imagining a traditional set of scales. When the case begins, the scales are even. After all the evidence has been presented, if the scales should remain even, or if they should tip, even slightly, in favor of the [respondent], then the plaintiff will have failed to meet his burden of proof and your verdict would be for the [respondent].

Section 1-2 Ervin's South Carolina Requests to Charge, S. C. Bar (1994).

The panel did not even attempt to understand or apply the burden of proof by which these proceedings are governed. The purported "findings of fact" set forth a recitation of what each witness testified to, without an analysis of the strength, veracity, credibility, or believability of

the witnesses. (Paragraphs 7, 8, 9, etc.⁶.) The panel made no effort to evaluate the evidence or decide what witnesses were found to be more knowledgeable on the facts or which provided more substantive research on the issues in question.

Clearly, as here, where the evidence does not "tip the scales" toward a conclusion that a licensee has deviated from the standard of care, a finding to that effect is legally unsound. A recitation of the evidence followed by a conclusion of law is insufficient to support a finding of misconduct. See *Treatment and Care of Luckabaugh*, 351 S.C 122, 568 S.E.2d 338 (2002)(requiring trial court to substantially comply with obligations to separately state findings pursuant to Rule 52(a), SCRCP).

The Board failed to establish, by a preponderance of evidence, that Respondent deviated from the standard of care. Accepting that they had not and could not define the standard of care applicable to these proceedings⁷, the panel attempted to by-pass their inability to articulate the standard of care by suggesting that its conclusions would apply "regardless of setting." (Report dated February 6, 2006, p. 4, para. 11).

However, even assuming the panel had been able to articulate the standard of care, the panel still did not analyze the evidence or make a determination that the allegation of misconduct had been established by the preponderance of evidence.

The most glaring evidence of the panel's lack of understanding of the issues before is the language in the final "finding" of fact.

Respondent placed sealant over obvious decay on several teeth. The decay was described by the dentist's hygienist as rampant before the patient was seen by the Respondent. The

⁶ Paragraph 6 even prefaces the paragraphs which follow by describing them as "a summary of a portion of the evidence." (Report dated February 6, 2006, p. 2).

⁷ As set forth in her memorandum and motion dated 3-23-06, it is necessary to set forth the standard of care in public health settings in order to evaluate any charge of misconduct in this matter.

Respondent coded the case as having no obvious problems when clearly a dentist's intervention was needed.

(emphasis added)(Report p. 4, para. 11).

The formal accusation in this case charged that respondent had placed sealant over only one tooth that had a carious lesion, that being tooth #3.⁸ (Formal Accusation Para. II(3)).

Notwithstanding the charge, the panel made a finding that Respondent had placed sealant over obvious decay "on several teeth." This was not charged as an element of misconduct, and therefore cannot form the basis of a finding of misconduct, without violating due process.

Zaman v. South Carolina Board of Medical Examiners, supra.

Issue Three

The panel erred (other than in failing to define the standard of proof) in not recognizing that the significant likelihood of no follow-up care should be considered in establishing the standard of care for dental hygienist in a public health setting.

Part of the reason the standard of care in the public health setting is the likelihood that students who are seen in the school setting by a dental hygienist will not obtain follow-up dental care, even though it is recommended. *See discussion* Motion and Memorandum dated 3-23-06. As demonstrated here, even when a student goes to a dentist, follow-up treatment by the dentist is far from a "sure thing."

The patient in question here did not follow up with Dr. Adams, and presumably still has caries on several teeth, if Dr. Adams' initial diagnosis was correct. (Tr. P. 16, lines 15-20; p. 17, lines 3 - 8). Unless he has received dental care elsewhere, the patient still has the benefit of the

⁸ The formal allegation also included a charge that Respondent placed sealant over tooth #30, which did not require a sealant. (Formal Accusation Para II(4)). Dr. Adams testified that he placed a partial occlusal on tooth #30 prior to Respondent seeing the patient, but he did not seal the remainder of the tooth because it had no decay present. (Tr. P. 26, lines 10-12). This illustrates Dr. Adams' lack of understanding of the use and purpose of sealants, which are preventative, not restorative. Moreover, Dr. Adams agreed that the placement of sealant on tooth #30 was beneficial to the patient, because the patient elected not to have any follow-up care and apparently had not obtained a restoration on that tooth. (Tr. P. 24, lines 1-11). For that reason, that charge was clearly without merit.

sealants in place, even partially, and therefore has a possibility that any caries on the sealed teeth have had their growth arrested or at least slowed. (Tr. P. 19, line 24 – p. 20, line 17).

According to Dr. Simonsen:

The literature is pretty clear on this, that if a sealant is partially lost the tooth is better off that had it not been placed, than if the sealant had not been placed. If there was caries under the sealant and it now becomes open again and communicative, the caries should resume at the same rate, maybe even less because the sealant will somewhat cut down the flow of oral fluids to that area.

(Beauchum Tr. P. 25, lines 4-18).

The testimony in this record establishes, without contradiction, that sealants cause no harm. Sealants are beneficial on teeth that have no caries present. They are beneficial on teeth that have some caries present. They are especially beneficial when the patient receives little or no follow-up dental care.

These cases are not about whether or not sealants are bad. This is not a philosophical debate about whether dentists in private practice should, or should not, use sealants. The issue here is what is the standard of care in a public health setting, where the likelihood of follow-up dental care is small. In finding professional misconduct based on a deviation from the standard of care, either some harm must have occurred, or at least the risk of harm must have been increased in some manner. That is not the case here.

Issues Four

A finding of professional misconduct based on a deviation from the standard of care in dental hygiene requires either a finding of harm to the patient or an increased risk of harm to the patient.

If a finding of misconduct is made here, it will be made based on testimony which shows that the Respondent placed sealants on teeth, which caused no harm to the patient and, in fact, likely benefited him. The record is very clear on this point.

Respondent respectfully submits that, in determining whether professional misconduct has occurred supporting the imposition of discipline, some harm or risk of harm must have occurred. There is no authority within the state, of which Respondents are aware, which addresses this issues specifically. However in considering the purpose of professional discipline, which is the protection of the public, Respondent would submit that, at a minimum, some risk of harm to the patient is a condition precedent to the imposition of professional discipline.

The ability to administratively sanction an individual arises out of the state's police power, which exists not to punish the individual, but to protect the public. *State v. Price*, 333 S.C. 267, 272, 510 S.E.2d 215, 218 (quoting *Parker v. State Highway Department*, 224 S.C. 263, 271, 78 S.E.2d 382, 386 (1953); *In re: Chastain*, 340 S.C. 356, 532 S.E.2d 264 (2000)). In that vein, the exercise of the police power requires something more than the philosophical disagreement by the licensing agency with the merits of a program approved and implemented by the legislature. See *Conway v. City of Greenville*, 254 S.C. 96, 101, 173 S.E.2d 648, 650 (1970) (while not unlimited, a municipality does have the authority in the exercise of the police power to enact zoning ordinances restricting the use of privately owned property).

Throughout the litigation of this matter, the Board has postulated that it is not necessary for it to show harm to a patient in order to discipline a licensee. Respondent submits that the police power does not permit discipline of hygienists employed by the school based dental program simply because the dentists community doesn't like it or feels threatened by the existence of the program. Should discipline be imposed in this proceeding, and thereby establish precedent holding that professional discipline can be imposed on licensees of the Dental Board without a showing of harm or risk of harm, Respondent would submit that the Dental Board will have a lot more work to do, because it will find itself regulating differences in

philosophy and management procedures among dentists with differing practice views.

Respondent would further submit that the imposition of professional discipline without a showing of harm or risk of harm is a violation of the State's police power, and therefore a violation of Respondent's constitutional rights.

Conclusion

For the reasons set forth above, and in the prior memorandum and motion dated March 22, 2006, the charges against Respondent should be dismissed.


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April 4, 2006

ROA Ct. of Appeals

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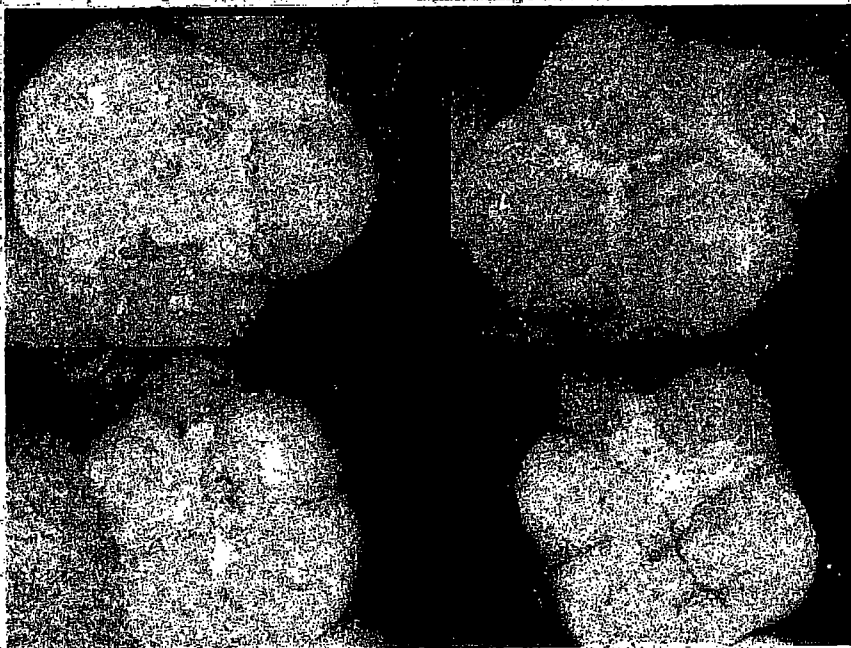
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ROA Ct. of Appeals

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AFTER SEALANT REMOVAL ! FISSUREDITY

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF DENTISTRY

Case No. 04-45

IN THE MATTER OF

[REDACTED] R.D.H.,

License No. [REDACTED]

Respondent.

MEMORANDUM TO BOARD

Respondent [REDACTED], RDH, objects to the Report and Recommendation in this matter dated February 6, 2006. Respondent's prior motion and memorandum, dated March 22, 2006, is incorporated herein by reference as fully as is repeated herein verbatim. In addition, Respondent would raise the following issues.

The Formal Accusation in this matter alleged that Respondent placed sealants over "gross caries on several teeth" of [REDACTED] M. [REDACTED] and M. [REDACTED] A. [REDACTED] (Formal Accusation Para. II(3)).

The panel found that Respondent did not deviate from the standard of care (although the standard of care was not defined) as to [REDACTED] M. [REDACTED] (T.M.), but did as to M. [REDACTED] A. [REDACTED] (M.A.).

Therefore, this memorandum primarily addresses the specific issues as to M. [REDACTED] A. [REDACTED]

Issue One

The complaint, the testimony of the treating dentist, and the panel failed to identify what teeth were allegedly inappropriately treated by Respondent.

The formal accusation did not specify which teeth of the patient M. [REDACTED] A. [REDACTED] formed the basis for the Board's allegations of professional misconduct against Respondent. *Id.* The testimony of the treating dentist, Dr. Chadwick, did not either, although he did, by reference to his chart, indicate what teeth he had filled when he first saw Ms. A. [REDACTED] (Tr. P. 50, lines 1 - 19).

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I did drill fillings on one side of the mouth. . . We did a lot of fillings. . . it looks as though we did about twelve filings on one side of her mouth . . . on that particular day.

Id. Dr. Chadwick agreed with the prosecution's attorney the identity of the teeth he filled was in his records, "in the left hand column." (Tr. P. 50, lines 17-19). He filled another twelve teeth, on the other side of the mouth, at the next visit, for a total of 24 fillings. (T. p. 51, lines 13-20). However, no one ever said which teeth they alleged Respondent should not have sealed.

Dr. Chadwick offered photos of several teeth, before he had excavated and restored them, showing the sealants placed on the teeth by Respondent. The identification on the photos reflects the number of the tooth shown in the photo. (Ex. A)(Tr. P. 53, lines 1-7). The photos identify teeth numbers 2, 3, 14, 15, 18, 19 and 31. (Pet. Ex. 3). As is evident from the photos, some of the teeth were only partially sealed. Dr. Chadwick's testimony is that he filled all of the "back teeth", including the ones shown in the photographs. (Tr. P. 51, lines 18-20).

The Respondent testified, and her records reflect, that she cleaned the patient's teeth and applied sealants on 2, 3, 14, 15, 19, 30 and 31 on April 27, 2003. (Pet. Ex. 4; Tr. P. 253, lines 2 - 16). She noted that there was decay throughout the mouth, the fissures were "incredibly stained" and the teeth were uniformly "sticky." *Id.* Respondent was knowledgeable enough not to use the explorer too firmly, because she is aware that you can cavitate the patient's teeth by doing so.¹ *Id.* "You can transfer bacterium from one tooth to another, so I try to be conservative about that." *Id.*

¹ There is literature which suggests that probing with a sharp explorer can aggravate non-caries lesions and generate cavitation. "Traditional probing with a sharp explorer has come into question as the ultimate determinant of caries activity. The exclusive use of a "catch" by the sharp explorer to diagnose caries in pit and fissure sites should be discontinued and clinicians are being called to use "sharp eyes and a blunt explorer". Also non-cavitated lesions can become cavitated simply through pressure from the explorer during the typical examination. Thus, penetration by a sharp explorer can actually cause cavitation in areas that are remineralizing or could be remineralized. An explorer can also transfer cariogenic bacteria from one tooth surface to another." (emphasis added) "Treating Caries as an Infectious Disease. JADA 125 (June):2-S to 15-S(1995) citing Elkstrand et al, 1987). Unfortunately, many dentists still apparently use the explorer aggressively, aggravating the cavitation.

We do not know which of M. A. [REDACTED] teeth were allegedly the subject of the deviation from the standard of care. The complaint didn't say, the testimony didn't say, and the panel didn't say, concluding only that Respondent had placed sealant "over obvious decay on several teeth." (Panel Report p. 5). In the absence of testimony and exhibits establishing exactly what teeth were allegedly the subject of the deviation from the standard of care, any finding of misconduct would be inappropriate and a deprivation of Respondent's due process rights.

Issue Two

The panel failed to recognize or apply the proper burden of proof in these proceedings. The evidence does not sustain a finding of misconduct by a preponderance of the evidence.

Under South Carolina law, a professional license issued by regulatory authorities is a "property interest" which requires that a disciplinary proceeding afford due process of law before a finding of misconduct can be made or professional discipline imposed. *Zaman v. South Carolina State Board of Medical Examiners*, 305 S.C. 281, 408 W.E.2d 213 (1991). While due process does not require any particular form of procedure, it does require that any misconduct be established by the preponderance of the evidence. *Anonymous v. State Board of Medical Examiners*, 329 S.C. 371, 496 S.E.2d 17 (1998).

Preponderance of the evidence is evidence is the "greater weight of the evidence" and "evidence which convinces" the fact finder "of its truth." *Lee v. Lee*, 237 S.C. 532, 118 S.E.2d 171 (1961); *In re: Marks*, 40 B.R. 614 (Ban.D.S.C. 1984). Findings of fact based on a preponderance of the evidence are "those supported by the greatest weight, amount, credibility or truth, as reflected by the whole of the evidence before the court." *Janasik v. Fairway Oaks Villa Horizontal Property Regime*, 307 S.C. 339, 415 S.E.2d 384 (1992).

What we mean by the greater weight of the evidence can be illustrated by imagining a traditional set of scales. When the case begins, the scales are even. After all the evidence has been presented, if the scales should remain even, or if they should tip, even slightly, in favor of the [respondent], then the plaintiff will have failed to meet his burden of proof and your verdict would be for the [respondent].

Section 1-2 Ervin's South Carolina Requests to Charge, S. C. Bar (1994).

The panel did not even attempt to understand or apply the burden of proof by which these proceedings are governed. The purported "findings of fact" set forth a recitation of what each witness testified to, without an analysis of the strength, veracity, credibility, or believability of the witnesses. (Paragraphs 6, 7, 8, 9, 10.²) The panel made no effort to evaluate the evidence or decide what witnesses were found to be more knowledgeable on the facts or which provided more substantive research on the issues in question, or which testimony was most persuasive.

Clearly, as here, where the evidence does not "tip the scales" toward a conclusion that a licensee has deviated from the standard of care, a finding to that effect is legally unsound. A recitation of the evidence followed by a conclusion of law is insufficient to support a finding of misconduct. *See Treatment and Care of Luckabaugh*, 351 S.C 122, 568 S.E.2d 338 (2002)(requiring trial court to substantially comply with obligations to separately state findings pursuant to Rule 52(a), SCRCP).

The Board failed to establish, by a preponderance of evidence, that Respondent deviated from the standard of care. Accepting that they had not and could not define the standard of care applicable to these proceedings³, the panel attempted to by-pass their inability to articulate the

² In discussing the testimony of Respondent's expert witness, Dr. Richard Simonsen, no attempt was made to assess the testimony; the paragraph was prefaced as "a summary of [Dr. Simonsen's] comments." (Report dated February 6, 2006, p. 3 para.9).

³ As set forth in her memorandum and motion dated 3-23-06, it is necessary to set forth the standard of care in public health settings in order to evaluate any charge of misconduct in this matter.

standard of care by suggesting that its conclusions would apply "regardless of setting." (Report dated February 6, 2006, p. 5, para. 11).

However, even assuming the panel had been able to articulate the standard of care, the panel still did not analyze the evidence or make a determination that the allegation of misconduct had been established by the preponderance of evidence.

In attempting to support its conclusions, the panel stated:

The evidence shows a large and extensive degree of decay which should have been obvious to the Respondent. The Respondent herself noted that decay was sticky throughout...

(Report p. 5, para. 11).

Clearly Respondent did see the decay; she is not charged with being unable to recognize decay. She saw it and she noted it., and sent the child to a dentist – Respondent did exactly as she was supposed to do, and benefited the patient in the process.

M. A. [REDACTED] had apparently never seen a dentist. Respondent's records indicated there were problems throughout the mouth, and she sent a letter to the patient's mother suggesting the child see a dentist. (Pet. Ex. 4). This is not a situation in which Respondent didn't see evidence of the likelihood of active caries and simply proceeded blindly. Respondent saw the evidence, and based on the factors known to her and the training she had received, as well as her experience, she sealed the teeth, knowing that the chance of the child seeing a dentist for additional care was slight. (Tr. P. 251, line 7 – p. 253, line 16).

Fortunately, M. A. [REDACTED] did see a dentist, which she likely would not have done but for the suggestion of the hygienist. M. A. [REDACTED] is an example of a success for the school-based dental health program, the ultimate goal of which is to get the children to see a dentist for further care. (Tr. P. 253 line 17 -0 p. 20). Respondent uses her own money to prepare "care"

packages to send home with each student, containing toothbrushes, toothpaste, and sticklers to generate the child's interest in good dental care. (Tr. P. 255 line 1 - 21). She also includes information about good dental care and sealants, which dispels any argument by Dr. Sneed of a false sense of security. *Id.*

The question here is whether, with the evidence before her, it was a deviation from the standard of care in the public health setting for sealants to be placed on the teeth which were suspected. In other words, was it a deviation from the standard of care to provide a benefit to the patient.

As discussed above, Respondent still does not know, from the complaint, the testimony, or the panel report, what teeth form the basis for her alleged misconduct. Without a specific charge, and specific evidence, this record cannot form the basis of a finding of misconduct, without violating due process. *Zaman v. South Carolina Board of Medical Examiners, supra.*

Issue Three

The panel erred (other than in failing to define the standard of proof) in not recognizing that the significant likelihood of no follow-up care should be considered in establishing the standard of care for dental hygienist in a public health setting.

Part of the reason the standard of care in the public health setting is the likelihood that students who are seen in the school setting by a dental hygienist will not obtain follow-up dental care, even though it is recommended. *See discussion* Motion and Memorandum dated 3-22-06. As demonstrated here, even when a student goes to a dentist, follow-up treatment by the dentist is far from a "sure thing."

The patient in question here had never seen a dentist before, and little reason to believe she would seek follow-up treatment after being seen by the hygienist. That being the case, in the public health setting, it is always better to seal, because of the likelihood that no follow-up care will be provided. Even if the seals are partially lost, some sealant is better than none, even with caries in place prior to the application of the sealant.

According to Dr. Simonsen:

The literature is pretty clear on this, that if a sealant is partially lost the tooth is better off that had it not been placed, than if the sealant had not been placed. If there was caries under the sealant and it now becomes open again and communicative, the caries should resume at the same rate, maybe even less because the sealant will somewhat cut down the flow of oral fluids to that area.

(██████ Tr. P. 25, lines 4-18).

Armed with the knowledge that her patients have not seen a dentist, and may never see a dentist, and with her training and experience, Respondent makes a judgment call as to whether to seal teeth that appear to be cavitated. (Tr. P. 251 line 19 – p. 252, line 9). In her experience, 60 percent of the children she sees do not receive follow-up dental care. *Id.*

I struggle and find that I am negligent if I just leave it open and just leave it there and not know if they're going to go to a dentist, I struggle with that. . . My heart is to take care of

that child. And I just feel like it's going to sit right there and grow [if I don't seal it]. . .
Even with my pitiful little contribution, I feel like I've done something [to help the child].

Id. Respondent does not seal gross decay. (Tr. P. 252, lines 18-22).

The testimony in this record establishes, without contradiction, that sealants cause no harm. Sealants are beneficial on teeth that have no caries present. They are beneficial on teeth that have some caries present. They are especially beneficial when the patient receives little or no follow-up dental care.

These cases are not about whether or not sealants are bad. This is not a philosophical debate about whether dentists in private practice should, or should not, use sealants. The issue here is what is the standard of care in a public health setting, where the likelihood of follow-up dental care is small. In finding professional misconduct based on a deviation from the standard of care, either some harm must have occurred, or at least the risk of harm must have been increased in some manner. That is not the case here.

Issues Four

A finding of professional misconduct based on a deviation from the standard of care in dental hygiene requires either a finding of harm to the patient or an increased risk of harm to the patient.

If a finding of misconduct is made here, it will be made based on testimony which shows that the Respondent placed sealants on teeth, which caused no harm to the patient and, had she not had follow-up care, would have benefited her. The record is very clear on this point.

Respondent respectfully submits that, in determining whether professional misconduct has occurred supporting the imposition of discipline, some harm or risk of harm must have occurred. There is no authority within the state, of which Respondents are aware, which addresses this issues specifically. However in considering the purpose of professional discipline,

which is the protection of the public, Respondent would submit that, at a minimum, some risk of harm to the patient is a condition precedent to the imposition of professional discipline.

The ability to administratively sanction an individual arises out of the state's police power, which exists not to punish the individual, but to protect the public. *State v. Price*, 333 S.C. 267, 272, 510 S.E.2d 215, 218 (quoting *Parker v. State Highway Department*, 224 S.C. 263, 271, 78 S.E.2d 382, 386 (1953); *In re: Chastain*, 340 S.C. 356, 532 S.E.2d 264 (2000)). In that vein, the exercise of the police power requires something more than the philosophical disagreement by the licensing agency with the merits of a program approved and implemented by the legislature. See *Conway v. City of Greenville*, 254 S.C. 96, 101, 173 S.E.2d 648, 650 (1970) (while not unlimited, a municipality does have the authority in the exercise of the police power to enact zoning ordinances restricting the use of privately owned property).

Throughout the litigation of this matter, the Board has postulated that it is not necessary for it to show harm to a patient in order to discipline a licensee. Respondent submits that the police power does not permit discipline of hygienists employed by the school based dental program simply because the dentists community doesn't like it or feels threatened by the existence of the program. Should discipline be imposed in this proceeding, and thereby establish precedent holding that professional discipline can be imposed on licensees of the Dental Board without a showing of harm or risk of harm, Respondent would submit that the Dental Board will have a lot more work to do, because it will find itself regulating differences in philosophy and management procedures among dentists with differing practice views. Respondent would further submit that the imposition of professional discipline without a showing of harm or risk of harm is a violation of the State's police power, and therefore a violation of Respondent's constitutional rights.

Conclusion

For the reasons set forth above, and in the prior memorandum and motion dated March 22, 2006, the charges against Respondent should be dismissed.



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ATTORNEYS FOR RESPONDENT

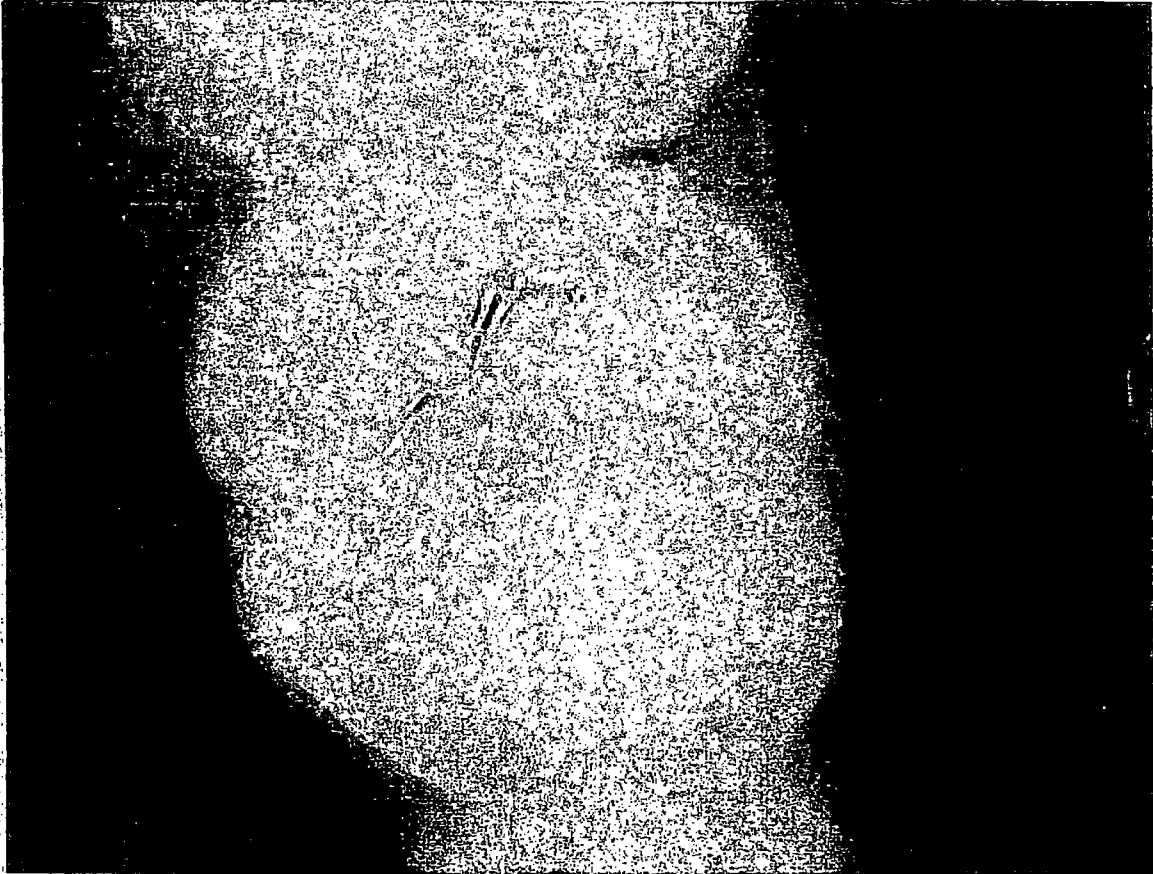
April 6, 2006

Patient

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Practice

Modern Family Dentistry
1818 Remount Rd.
Hanahan, SC 29406
843-744-6971



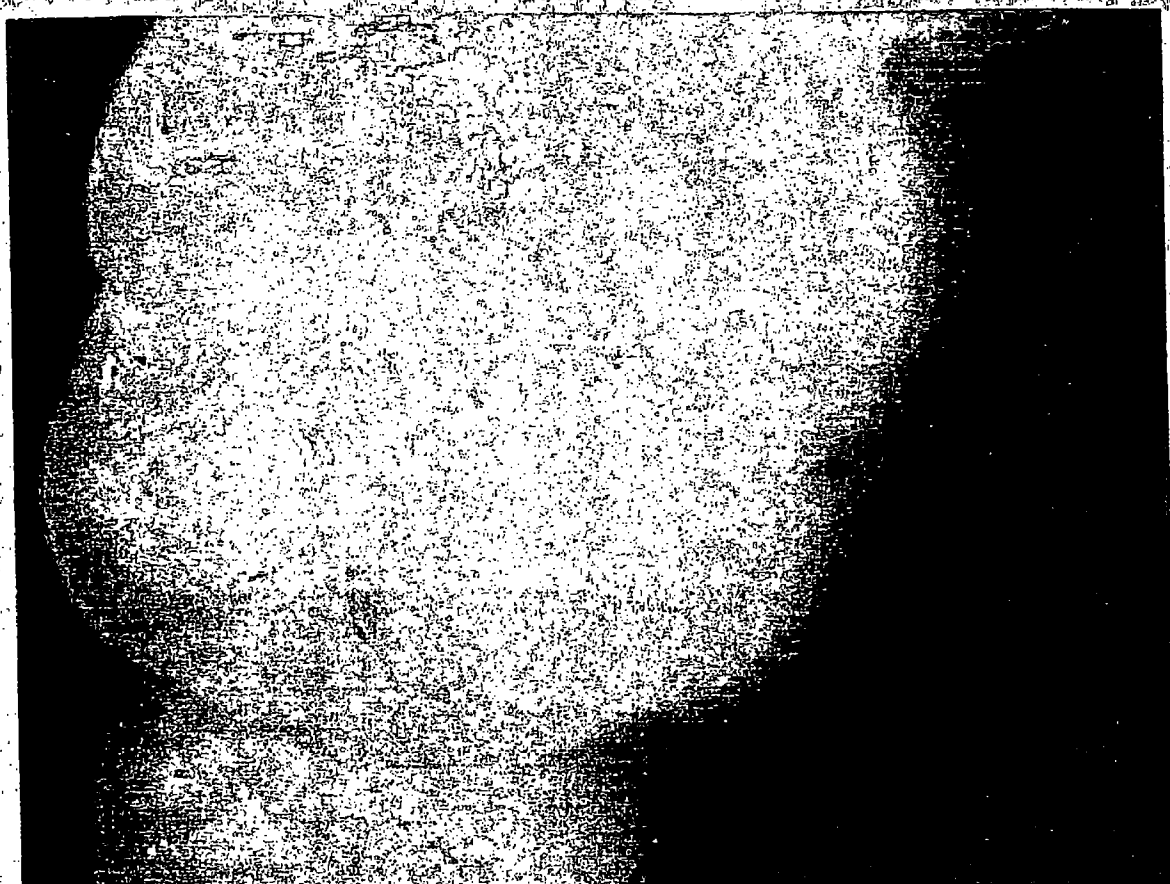
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Patient

[REDACTED]
[REDACTED]
[REDACTED]

Practice

Modern Family Dentistry
1818 Remount Rd.
Hanahan, SC 29406
843-744-6971



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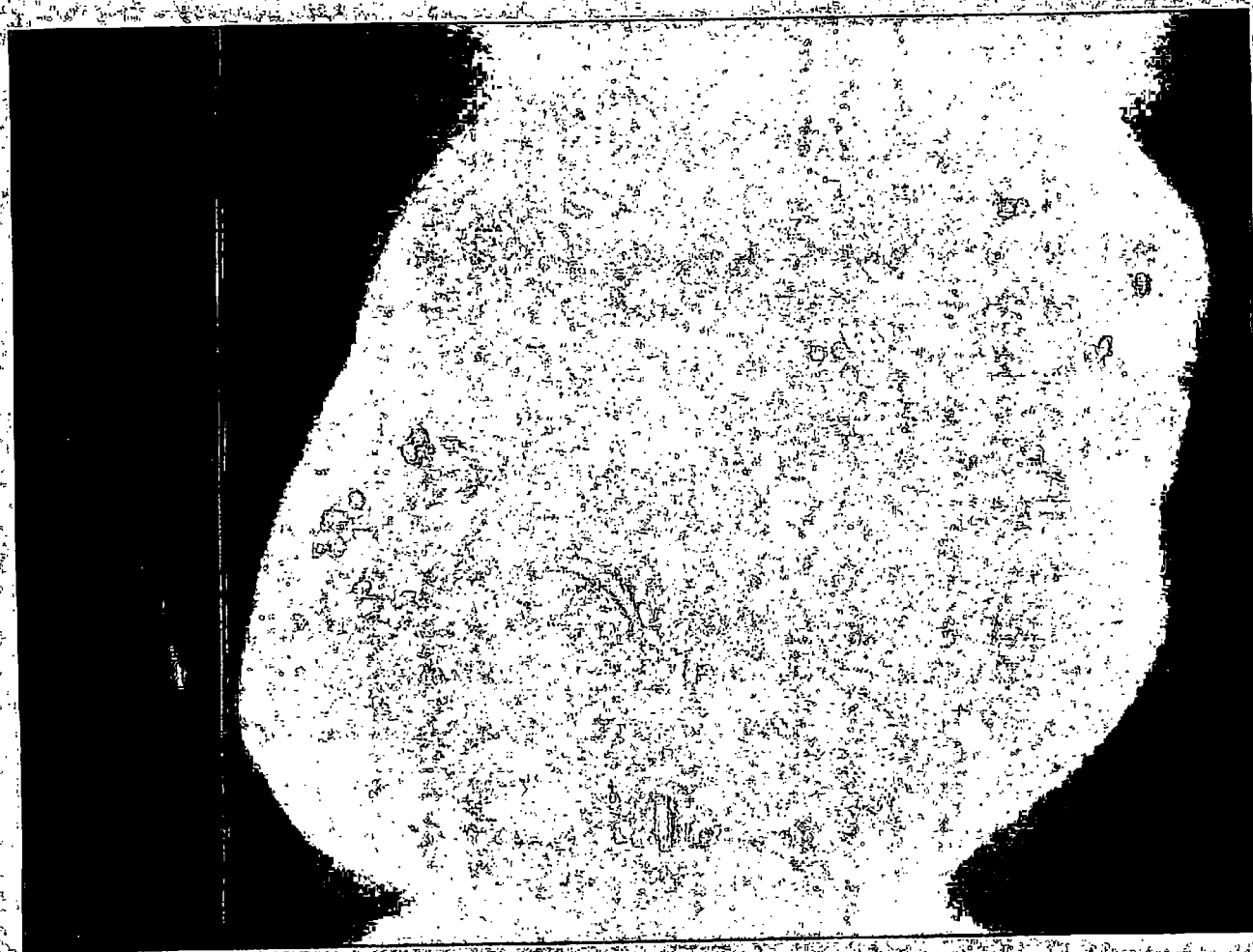
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Patient

Practice

Modern Family Dentistry
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ROA Ct. of Appeals

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Patient

A [REDACTED] M

Practice

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05/08/2003 18

ROA Ct. of Appeals

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Patient

Practice

Age [REDACTED] M

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05/08/2003 31

ROA Ct. of Appeals

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Patient

Practice

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05/08/2003 19

ROA Ct. of Appeals

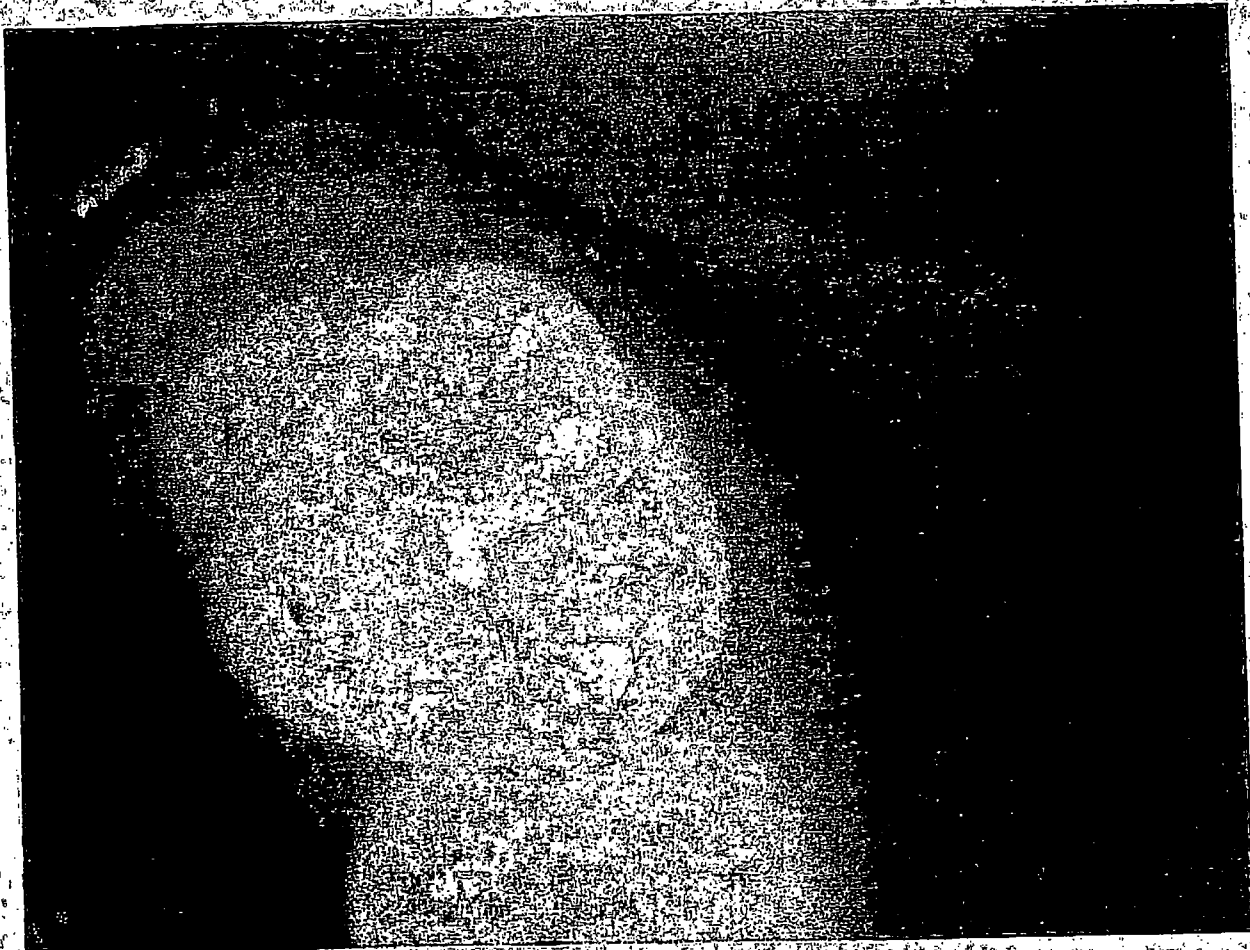
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Patient

Practice

A. M.
[Redacted]

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ROA Ct. of Appeals
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April 06, 2006

Via U.S. Mail Only
Rion Alvey
Board of Dentistry
110 Centerview Drive
Kingstree Building
Columbia, South Carolina 29210

Re: [REDACTED], Case No. 04-45

Dear Rion:

As a supplement to the brief dated March 22, 2006, which was applicable in all cases, I am submitting a brief for the Board in Mrs. [REDACTED] case. I have enclosed ten (10) copies, all of which have the attachment photocopied in color; this should be one for your files and 9 for the individual Board members. Please note that I have also served a copy of the memorandum on Mr. Woodington, with color attachments.

I would appreciate you submitting this to the Board in advance of the hearing on April 29, 2006. With warm personal regards, I am,

Sincerely yours,

Desa Ballard

Desa Ballard
E-mail: desab@desaballard.com

c: ✓ Ken Woodington, Esquire
Tammi Byrd, Health Promotion Specialists
[REDACTED], R.D.H.
(all with copy of enclosures)

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

)
)
)
AFFIDAVIT OF TAMMI O. BYRD

Personally appeared before me, Tammi O. Byrd, who after being duly sworn, states and deposes the following:

1. I am over the age of eighteen (18) years and am competent to state the matters set forth herein. I have personal knowledge of the matters set forth, except as to those matters as are stated on information and belief, and as to those, I have a good faith basis for believing them to be true.
2. I am the co-owner and CEO of Health Promotion Specialists, LLC (hereinafter HPS) located in Lexington, South Carolina.
3. Below is a recitation of some of the events which occurred with the Dental Board, the South Carolina Dental Association (hereinafter SCDA) and individual dentists in South Carolina regarding HPS and the services it provides:
 - a. Edward Herschaft, DDS, a professor at the Dental School at MUSC and currently HPS' authorizing dentist, indicated in his sworn deposition in mid 2005 that Dr. Charlie Hook, Assistant Dean at the Dental School at the Medical University of South Carolina (hereinafter MUSC) told him in October 2000 that he could not work with HPS in the school based dental program. Dr. Herschaft had previously spoken with counsel and was advised that there was no conflict.
 - b. In December 2000, Dr. Millwood, SCDA President, wrote an article implying that we offered "substandard care". However, at the February 2001 South

Carolina Dental Board meeting I made a presentation on behalf of HPS about our program and I asked if there were any questions or concerns. Dr. Millwood asked me how we could do a sealant without proper equipment or being able to dry a tooth. I explained to Dr. Millwood what kind of equipment we used to isolate a tooth, dry it and seal it. At that point, Dr. McBride, our supervising dentist, asked Dr. Millwood, how he could write an article in December 2000 implying that we offered "substandard care" if he wasn't even aware of what type of equipment we used.

- c. On information and belief, on or about March 16, 2001 the SCDA met and it was reported that HPS had screened and cleaned an entire third grade class in one day. Not only was that a false statement, but it referred to a school that HPS had never been to. In the minutes from this meeting, the SCDA inaccurately reported that at that time HPS was not permitted to work in Williamsburg County. However HPS was working in Williamsburg County.
- d. On or about May 2001, the SCDA Bulletin stated that SCDA paved the way to improving Medicaid and now this small group of hygienists is stealing the patients and the Medicaid money is going to run out. Millwood talked about "cream off the top" and that the local dentists will not see children if they are seen by HPS.
- e. In June 2001, there are several emails between Dr. Ernie Myrick, practicing dentist in Clover, York District 2, and the SCDA that confirm they collaborated to meet with school officials, call other dentists around the state, and send a mailing to York 2 school board members in an effort to stop the

school based dental health program. The mailing is full of misleading and false information. The letter states that "if other school districts across the state follow your footsteps, ...the entire Medicaid dental program will become insolvent. Abuse of these funds will result in fewer children with disease receiving relief from their pain." The letter was sent prior to mailing to Hal Zorn, Executive Director of SCDA, and reviewed by Mr. Zorn and Phil Latham, Assistant Director of SCDA, who are believed to have acted on behalf of the SCDA in doing so.

- f. On July 10, 2001, the Gaffney Chronicle ran an article highlighted on their front page containing a SCDA letter that was sent to all school nurses, school board members, and school superintendents. On information and belief, one of HPS's dental hygienist heard the letter being read over the air on a local Gaffney radio station. I made a presentation on behalf of HPS at the Gaffney School Board meeting that evening. Mr. Ron Barrett introduced himself as Immediate Past President of the South Carolina Dental Board and a member of the SCDA. He then stated that the services HPS provides are illegal and that the Board will do what it takes to stop them. Numerous local dentists spoke against HPS. Dr. John Hubbard stated that HPS provides "third world dentistry." Dr. Carroll stated that dental hygienists are not qualified to see children without a dentist being present.
- g. On July 13, 2001, the South Carolina Dental Board enacted an emergency temporary regulation which reinstated prior language removed by the legislature. The regulation now stated that a child must be seen by a dentist

within 45 days prior to being seen in a school setting.

- h. In August 2001, HPS and Palmetto Dental Care filed suit against the South Carolina Dental Board and the SCDA. The allegations included, but were not limited to antitrust – Sherman Act, Sect. 1, intentional interference with a contractual relationship, intentional interference with prospective advantage, business defamation, civil conspiracy and violation of Unfair Trade Practices Act.
- i. Upon information and belief, in or around August 2001, Jay Evans, acting on behalf of the South Carolina Dental Board went to the home of Linda Clemenz, co-owner and Chief Operating Officer of HPS, where the HPS records were maintained. Jay Evans produced a subpoena and without notice, started reviewing files. Mr. Evans took 32 original files with him and to date only 1 of these files has been returned to HPS. There have been no allegations stemming from any of the files removed from HPS.
- j. In the September 2001 SCDA Bulletin, there was an article which indicated that the civil litigation against the SCDA involved unauthorized dental procedures. On page 3 of the Bulletin, the attorney's report states that the reason the SCDA supported the change in law was the Board assured them the board policy of requiring an exam would remain in effect.
- k. On October 2, 2001 I met with Eric Schell and Dr. Venus Holland, representatives of Lexington District 2. They stated that the school nurses wanted HPS to work in Lexington District 2 and they were very much in favor of HPS providing services there. However, on information and belief, the

efforts of the SCDA in opposing the program to publish false information on about the program created bad press and questions in the community. It was believed, due to SCDA's efforts, that HPS is being sued and that the district would become involved if they allow the services. The district asked me to keep them informed of the "lawsuit situation." They wanted us to start as soon as there was some form of closure with the lawsuit. There was no lawsuit against HPS.

- l. On October 18, 2001, a guest column appeared in The State written by Dr. J. Capers Hiott, president of the South Carolina Medical Association. Dr. Hiott's letter is very misleading and biased.
- m. In January 2002, the Administrative Law Court ruled that the emergency temporary regulation was against the intent of the statute. Two days after his ruling, the emergency temporary regulation expired and the issue was moot. The South Carolina Dental Board did not utilize the legislative process to re-submit the regulation to become permanent.
- n. On or about March 6, 2002, the SCDA mailed a pamphlet out about the school based programs to provide care to children. The SCDA falsely reported that HPS would not see children that had restorative needs. The pamphlet was sent to the Department of Health and Environmental Control (hereinafter DHEC) for review before being mailed. Dr. Lala, the State public health dentist at the time, told me that he noted 20 corrections that needed to be made in order for the brochure to be accurate and not misleading. The SCDA chose not to make any changes and mailed the pamphlet out as is. The Memorandum of

Agreement between HPS and DHEC states that children with "urgent" needs will have their pain alleviated before preventative services are performed at the school. Urgent needs are defined as pain and/or swelling. Most children seen by HPS have restorative needs.

- o. In March 2002, the SC Dental Board adopted a "policy" stating that "authorized" means that a dentist has personally examined each and every child. This policy is in direct conflict with the legislature and the Administrative Law Court ruling.
- p. On July 19, 2002, the South Carolina Dental Board released a new proposed statute change that would define "authorization" and "oral diagnosis." Since Judge Kittrell from the Administrative Law Court ruled that an exam prior to services was against the intent of the statute, the Board attempted to re-define the authorization necessary for general supervision which would again require a child to be seen by a dentist prior to being seen in the public school setting. On information and belief, the SCDA provided these definitions to the Board from "Proposed ADA Language." The proposed language goes further to state that "general supervision is not acceptable to the American Dental Association because it fails to protect the health of the public." It then sets out the terms that must be followed if a state has general supervision, which includes many directives and definitions, to make the laws tolerable to the American Dental Association.
- q. On information and belief, on July 22, 2002 the South Carolina Dental Board mailed a letter to Sherie Williams, SCDHA President, which included the

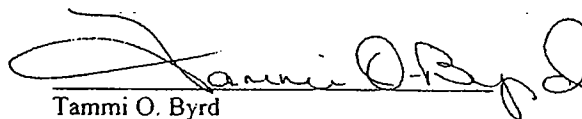
"proposed changes." The letter states that the terms were agreed upon during the July 19, 2002 meeting. This is a false statement. Mrs. Beverly Dunbar, chair for the Council on Regulation and Practice for SCDHA and instructor of dental hygiene at Midlands Tech, specifically asked that it be reported that the SC Dental Hygiene Educators and the SC Dental Hygiene Association (hereinafter SCDHA) did not approve of the changes at this time. Another meeting was scheduled for August 23, 2002.

- r. On information and belief, on May 10, 2003, the South Carolina Dental Board held a meeting to vote on the FTC settlement. Upon information and belief, Sherie Williams attended as the SCDHA liaison. Tanya Riffe, a dental hygienist who sits on the South Carolina Dental Board, was not present at this meeting. Sherie was escorted out of the meeting at 9:10 a.m. and told that the meeting would be in executive session. At 12:43 p.m, she was invited back into the meeting. The meeting was immediately adjourned. Tanya Riffe, later told me that she had not been informed of the South Carolina Dental Board meeting on May 10, 2003.
- s. On information and belief, May 27, 2003, the South Carolina Dental Board held a conference call meeting. Bryan Clemenz attended as a member of the general public. The meeting was held in executive session. He was invited back in the room and told that the motion on the floor was "to not accept a settlement with the FTC." The vote was unanimous. It was stated that Tanya Riffe was not included in the call for "legal reasons." Tanya again told me that she was not informed that a South Carolina Dental Board conference call was

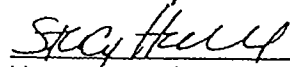
being held that day.

- t. On information and belief, on September 3, 2003, the South Carolina Dental Board held another meeting in executive session. In public session, the South Carolina Dental Board voted to decline to settle the administrative matter before it. Tanya Riffe was not present at this meeting and later told me that she was not informed of this meeting as well.
- u. That South Carolina Dental Board is currently defending allegations brought against it by the Federal Trade Commission which allege that the Board acted illegally in keeping children in South Carolina from receiving preventative dental care. This stems from the continued efforts of the Board to prevent the operation of the school based, public health dental program which provides preventative health care for school-aged children.

Further, deponent sayeth not.


Tammi O. Byrd

Sworn to before me this
21st day of April, 2006


Notary public for South Carolina

My commission expires: 11/16/2015

SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING & REGULATION
BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:) REVISED TRANSCRIPT
ANONYMOUS NO. 1, R.D.H.) WITH REDACTED NAMES
License No. 1113) PURSUANT TO ORDER OF
Respondent.) CAROLYN C. MATTHEWS,
-----) ADMINISTRATIVE LAW
) JUDGE, DATED
) AUGUST 2, 2006
) (Order attached)

PANEL HEARING

COPY

Friday, December 2, 2005
10:15 a.m. - 5:41 p.m.

The Panel Hearing before the South Carolina State Board of Dentistry was held at the Synergy Office Park, Kingstree Building, Room 113, 110 Centerview Drive, Columbia, South Carolina, on the 2nd day of December, 2005 before Robin K. Reibold, Court Reporter and Notary Public in and for the State of South Carolina.

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APPEARANCES

BOARD MEMBERS:

Douglas S. Rawls, D.M.D., Chairman *p. 1194*
 Ben Jett, D.M.D. *p. 1182*
 Paul Coombs, D.M.D. *p. 1168*
 Charles Wade, D.M.D. *p. 1249, 1202*
 Deborah P. Baker, R.D.H.

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EXHIBITS

Petitioner's Exhibit Number One	5
(Dr. Sneed, Curriculum Vitae)	
Petitioner's Exhibit Number Two	5
(M.A. Chart - Dr. Chadwick)	

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(3 Photographs, M.A.)	
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STIPULATIONS

Upon stipulation and agreement by all parties, Petitioner's Exhibit Numbers Twelve through Twenty-three and Respondents' Exhibit Numbers Thirteen through Eighteen are to be incorporated into this hearing.

It is further stipulated and agreed that this hearing is being taken pursuant to the Administrative Procedures Act, the Practice Act and Regulations of the Board.

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1 (Petitioner's Exhibit Numbers One through Eight and
2 Respondents' Exhibit Numbers One through Eleven, with
3 the exception of Number Seven, were marked and
4 entered into the record prior to the hearing by
5 stipulation and agreement by both parties.)

6 CHAIRMAN RAWLS: We'll call this hearing to order.

7 This is a hearing in the matter of Anonymous
8 No. 1, RDH, being held in Columbia, South
9 Carolina the 2nd day of December, 2005. My name
10 is Dr. Douglas Rawls, I'm the Chairman of this
11 hearing. Other members of the panel in this
12 case are Doctor... on my left Dr. Ben Jett, Dr.
13 Paul Coombs, Dr. Charles Wade, and Deborah
14 Baker, RDH. The Board is represented by Mr.
15 Louis Rosen. The Respondent is represented by
16 Ms. Desa Ballard and also Mr. Creighton
17 Coleman. The State is represented by Mr. Ken
18 Woodington. I would ask the attorneys at this
19 time to vouch for the eligibility to attend
20 this hearing of all the folks in the back. Is
21 there anybody that appears questionable?

22 MR. ROSEN: We're not familiar with all the faces
23 here and this is a confidential proceeding, so
24 I just wanted to be sure that both parties can
25 vouch for some connection every individual in

1 here has with the case.

2 MR. WOODINGTON: The best way to do that, because I
3 don't know all these folks myself and Desa may
4 not either. If you ... I would just ask
5 anybody that's connected with LLR, that's going
6 to be a witness for the State to stand, and
7 that includes the people that are included in
8 the LLR. Please stand if you're ... if you're
9 one of my witness or a potential witness of
10 mine for LLR.

11 MS. BALLARD: Who are they, for the record?

12 DR. RAWLS: Kathy Prince, who is the chief
13 investigator for LLR; Sheridan Spoon, attorney
14 for LLR.

15 MS. BALLARD: Mr. Spoon ...

16 MR. WOODINGTON: Sheila Jones, I believe ...

17 MS. BALLARD: Hold on, hold on, Mr. Spoon. Okay.
18 Just making sure I understand, and we do not
19 have a case together. I'm sorry.

20 MR. WOODINGTON: Sheila Jones with the Dental Board.

21 MS. BALLARD: Okay.

22 MR. WOODINGTON: Katherine Wade, a hygienist and a
23 possible witness. Dr. Stephen Chadwick and Dr.
24 Sneed.

25 MS. BALLARD: And the folks who are here as witnesses

1 or with the Respondents, please stand so that
2 we can introduce everyone. This is Michelle
3 and Anonymous No. 1. This is Michelle Love,
4 who is my paralegal; this is Anonymous No. 1,
5 who is the Respondent in this case. This is
6 Beverly Dunbar, who is a witness; this is Dr.
7 Richard Simonsen, who is an expert witness.
8 Tammi Byrd, who is with HPS; Linda ...

9 MS. CLEMMONS: Clemmons.

10 MS. BALLARD: Clemmons with HPS, and the many
11 Respondents, Anonymous No. 3, Anonymous No. 4,
12 and Anonymous No. 2. There's somebody in the
13 back? I'm sorry, Chris Veschucio here, and
14 (name intentionally omitted), the husband of
15 the Respondent in this particular proceeding.

16 DR. RAWLS: Thank you.

17 MR. WOODINGTON: We have no objection to anybody that
18 she named.

19 MS. BALLARD: Nor do we.

20 CHAIRMAN RAWLS: First of all I apologize for getting
21 a late start due to circumstances outside of
22 our control. This hearing will be conducted as
23 informally as is compatible with the equitable
24 presentation of both sides of the case in
25 compliance with the provisions of the

1 Administrative Procedures Act, the Practice
2 Act, and Regulations of the Board. The State
3 as the Respondent may, if they so desire, make
4 opening statements, thereafter the State shall
5 present its case, then the Respondent will
6 present her case. Both parties may make
7 closing statements if they wish; the State will
8 be ... will have the option of a closing
9 statement in reply. Are there any issues to be
10 addressed prior to the beginning of this
11 hearing?

12 MS. BALLARD: On behalf of Respondents, we have
13 several preliminary issues, if I may your
14 Honor. We have in our Answer, a preliminary
15 motion requesting disclosure to us of a copy of
16 the initial complaint in this action. 40-15-
17 180, which is the statute that authorizes the
18 Dental Board to proceed in these type matters,
19 requires that an initial complaint be received
20 by the Board in the form of a written affidavit
21 notarized by a complainant. Section 45-15-180
22 does not allow this Board to proceed with
23 disciplinary proceedings against a respondent
24 unless the Board has received an initial
25 complaint under oath by a complainant. We have

1 moved for a copy of that complaint to be
2 produced in all four matters, not just the
3 Anonymous No. 1 matter, but the other matters
4 as well. It is our position that under the
5 Girgis case from the South Carolina Court of
6 Appeals, that we are entitled to ... that we
7 are entitled to a copy of the complaint. We
8 requested the complaint from Mr. Aldi several
9 months ago, and our request was denied, with
10 Mr. Aldi acting on behalf of the Board. That
11 matter was appealed to the Administrative Law
12 Court, and Judge Marvin Kittrell hear oral
13 arguments on those approximately a month ago.
14 He ruled, not that we were not entitled to
15 copies of them, but that he could not address
16 the issue at this preliminary stage and that I
17 needed to request of the Board, which this
18 panel of course is an arm of the Board, to
19 receive copies of those complaints. The reason
20 why we need those complaints for purposes of
21 this proceeding is for purposes of cross-
22 examining any witnesses who may also be
23 complainants. We don't even know the identity
24 of the complainants in this case. And if the
25 State intends to call any of the initial

1 complainants, we have a right to cross-examine
2 them on statements that they have made to this
3 Board. Also, there is a statute, and I cannot
4 remember the number of it off the top of my
5 head, which prohibits any ex parte
6 communications with parties or witnesses with
7 this Board, because our position that a
8 complaint filed under 40-15-180 would in fact
9 be an ex parte communication, unless I'm
10 provided a copy of it in order to effectively
11 prepare my case. The Board ... the Dental,
12 excuse me, the nursing Board and the Board of
13 Medical Examiners in the past have objected to
14 production of initial complaints, citing
15 language in the various enabling statutes
16 regarding confidentiality. The Supreme Court
17 and the Court of Appeals have ruled that the
18 confidentiality as to the proceedings
19 generally, and not as to the parties to the
20 proceedings, therefore the provision in 40-15-
21 180 that makes the initial complaint
22 confidential does not prevent disclosure to the
23 parties in this proceeding. Secondly, the
24 *Girgis* case construed language similar to the
25 language in the Dental Board enabling statutes

1 that suggest that complaints are privileged as
2 attaching a ... an issue of civil immunity, a
3 certain level of qualified civil immunity to
4 the complaints, not protection from disclosure.
5 So we believe it is necessary, and in fact
6 critical for our purposes of cross-examination,
7 that we receive copies of the initial
8 complaints that were filed in each of these
9 cases pursuant to 14-15-180, because the Board,
10 first of all, has no authority to proceed in
11 the absence of having received those verified
12 complaints, and secondly so that we may
13 effectively cross-examine.

14 MR. WOODINGTON: If I may be heard on that for just a
15 moment, Mr. Chairman. It's basically our
16 position that the Dental Board has instructed
17 ... the full current active Dental Board has
18 instructed Mr. Aldi to deny all requests for
19 the initial complaints, including the ones in
20 these cases and in any other case, and that
21 that is a decision that's already been made in
22 this matter effectively by the Board and should
23 be just not considered by this panel at this
24 time. She's made the motion, she's protected
25 the record, she will no doubt make an appeal to

1 the Circuit Court if she loses any of these
2 cases based on that, or I assume she would, to
3 the Administrative Law Court, and that's fine.
4 But it's our position that that's not an issue
5 that's appropriate for this panel to decide.
6 If you disagree with me on that and conclude
7 that the panel should decide it, we would still
8 submit that the request to see the initial
9 complaints should be denied, and that's to
10 protect the complainants. The dental Board
11 itself and LLR don't have anything to hide in
12 this matter, but when people file complaints in
13 these matters they understand, or they are
14 given to understand, that their identity and
15 the contents of the complaint will be
16 confidential. There is no possibility that
17 somebody is going to be ... that communication
18 is going to take place between the dental Board
19 or this panel between the complainant and ...
20 with the complaint form because you don't ...
21 you haven't seen it, you won't see it, you
22 don't know who the complainant is, you don't
23 know what the contents of the complaint are,
24 and what you're going ... what you're going to
25 hear is what's placed in evidence before you

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1 today, and that's all. It's our position that
2 the statute ... the dental Board statute is not
3 the same as the medical board statute and that
4 it's more strict on confidentiality and that
5 access to the complaint should be denied for
6 that reason also. I would actually, Mr.
7 Chairman, ask that not only you deny the
8 request that they've made to see the initial
9 complaints, that you also deny the request to
10 find out the identity of the complainants, and
11 that finally, that any questions of any
12 witnesses in this matter that relate to that
13 should be ... well, I can object to them, but
14 they should not be permitted because it's
15 beyond the scope of this proceeding. It's just
16 an issue that shouldn't come before this panel
17 at all in this proceeding. That's our
18 position, Your Honor.

19 MS. BALLARD: With reference to the last issue, and
20 we can address that as an evidentiary issue,
21 but we do intend to request or to ask all of
22 the witnesses who testify whether they have
23 filed complaints with the Board; that is
24 directly relevant to issues of bias which we
25 are constitutionally entitled to inquire into

1 in a proceeding of this nature. Any refusal or
2 any ruling by the panel which would prohibit
3 the witnesses from answering those questions
4 would seriously infringe on the constitutional
5 rights of our clients to actively defend
6 themselves in these proceedings. Secondly,
7 that portion of the statute which prohibits ex
8 parte communication does not prohibit ex parte
9 communication with this panel, it prohibits ex
10 parte communication at any time with the Board
11 as a whole. The very definition of 40-15-180
12 is, when a complaint is received by the Board,
13 so if the complaint is received by the Board I
14 am entitled to have a copy of it, because there
15 cannot be any ex parte communications with this
16 Board; it taints the entire process, it
17 invalidates our ability to be able to
18 effectively cross-examine any witnesses that
19 might be called against us. We don't even know
20 who these complainants are, so we are going to
21 have to ask each and every witness who is put
22 up against us, we're going to have to ask them
23 those questions, and this panel is going to
24 have to rule on that issue with each and every
25 witness that comes before us. Lastly, the

1 confidentiality issues as discussed by the
2 courts in Girgis and the other opinions have
3 clearly indicated that it is applicable to
4 language of this type in these proceedings, and
5 we would move that before these proceedings go
6 forward that we be given a copy of the
7 complaints in each of them. We would also take
8 the position that if the Board has not received
9 affidavits under the mandatory statutorily
10 required form, which I will hand up, a copy of
11 it has been marked as Respondent's Exhibit
12 Number Two. If the Board has not received a
13 mandatory complaint, verified under oath by
14 affidavit, that these proceedings are illegal
15 and are unlawful and cannot move forward
16 without violating the statute. I'd like hand
17 up to each of the panel members copy of
18 Respondent's Exhibit Number Two, which is the
19 official complaint form mandated by the General
20 Assembly, before this Board may proceed with
21 complaints against any licensee.

22 MR. WOODINGTON: This has already been ...

23 MS. BALLARD: It's already been marked and introduced
24 into evidence without objection.

25 MS. BALLARD: Mr. Coleman wanted to comment as well.

1 MR. COLEMAN: I just wanted to make a comment. As a
2 former prosecutor for seven years, I prosecuted
3 here in Richland County for five and two years
4 over in Mr. Wade's area, the Sixth Circuit,
5 which is Fairfield, Chester, and Lancaster
6 Counties. It is unfathomable, in my opinion,
7 to allow proceedings to go on in which the
8 Respondents, and I try to have an analogy with
9 this with the criminal justice system, for the
10 Respondents here to not have the complaints, to
11 know who complained, and know what's in the
12 complaint. And if you think about it, look at
13 it on the criminal justice side. I mean, if a
14 person is charged with something, he's sent a
15 warrant and he is noticed with the indictment.
16 The purpose of that is to fully inform the
17 defendant of the charges and who made the
18 charges so they can properly prepare their case
19 to come before the court. There is nothing
20 different than that and what we're here today
21 about, to put the Respondents on notice as to
22 what the allegations are and who made the
23 allegations. And I think clearly, without
24 allowing that to occur, you violate every
25 fundamental right that America stands for, and

1 I would just urge you to go along with our
2 motion. Thank you so much.

3 MS. BALLARD: I did want to add one additional
4 comment. Mr. Woodington indicated that these
5 complainants would have submitted their
6 complaints to the Board, with the Board having
7 given them assurance that they would be
8 confidential and would not be disclosed. The
9 Board cannot alter the mandatory nature of the
10 statutes, they cannot grant assurance that the
11 law does not provide. If the Board
12 misrepresented to complainants that their
13 complaints were not subject to disclosure, that
14 is not grounds to prohibit disclosure to us.
15 They were simply wrong within the law.

16 MR. ROSEN: I am going to advise the Board that in my
17 opinion I do think that the dental Board's
18 statute in this regard is sufficiently similar
19 to the medical board's statute that was at
20 issue in *Girgis*, that I think that *Girgis*
21 applies here. However I think that some of the
22 issues that Mr. Woodington has raised are also
23 important and that the panel does need to weigh
24 those issues as well, and I suggest to you,
25 Chairman, that you entertain a motion to go

1 into executive session and that we discuss the
2 issue and then come back.

3 MS. BALLARD: We have no objection to that.

4 DR. COOMBS: I'll make a motion that the panel move
5 to executive session.

6 CHAIRMAN RAWLS: Dr. Coombs has made the motion.

7 DR. WADE: Second.

8 MS. BALLARD: Could I make one question before we ...
9 should we make all of our motions before we go
10 into executive session, or do them one at a
11 time?

12 MR. ROSEN: Are you talking about other issues?

13 MS. BALLARD: Yes. Do you want to do one issue at a
14 time?

15 MR. ROSEN: Let's do ... let's just deal with the
16 initial complaint issue.

17 MS. BALLARD: Thank you.

18 CHAIRMAN RAWLS: All in favor of executive session
19 say aye.

20 ALL: Aye.

21 MS. BALLARD: Do you want us to leave?

22 CHAIRMAN RAWLS: I think it would be easier for us to
23 go over there than it is for everyone else to
24 have to leave.

25 (Executive session, 10:32 a.m. to 11:01 a.m.)

1 CHAIRMAN RAWLS: First of all, I would like to ask
2 for a motion that we come out of the executive
3 session.

4 DR. COOMBS: I move that the panel comes out of
5 executive session.

6 DR. WADES: I'll second that motion.

7 CHAIRMAN RAWLS: All in favor say aye.

8 ALL: Aye.

9 CHAIRMAN RAWLS: I would now ask for a motion
10 concerning the issue that was raised.

11 DR. JETT: I would move that the initial complaints
12 in this matter not be provided to the
13 Respondent, as has been the previous policy of
14 the Board.

15 CHAIRMAN RAWLS: I heard the motion, is there a
16 second?

17 MS. BARBER: I second it.

18 CHAIRMAN RAWLS: All in favor say aye.

19 ALL: Aye.

20 MS. BALLARD: Could I ask for a specific ruling on
21 the issues that we have raised, regarding due
22 process, regarding the ex parte communications,
23 and regarding the legality of these
24 proceedings?

25 MR. ROSEN: Well, those ... those have all been

1 denied ...

2 MS. BALLARD: So all three of those grounds have been
3 overruled?

4 MR. ROSEN: All three.

5 MS. BALLARD: I just needed that clear for the
6 record.

7 MR. ROSEN: They have all been discussed. There has
8 been discussion of Girgis. We had a very full
9 discussion.

10 MS. BALLARD: Thank you.

11 CHAIRMAN RAWLS: Are there any ... any other issues
12 to be raised?

13 MS. BALLARD: Yes, Mr. Chairman. On behalf of the
14 Respondents in all four cases, we have
15 requested that certain members of the list of
16 potential panel members be removed from
17 consideration for serving as panel members in
18 this case, and it frankly was my understanding,
19 no fault of Mr. Woodington's, but it was my
20 understanding that that had been accomplished.
21 Unfortunately it had been not been
22 accomplished, and there are a couple of the
23 present sitting Board members who we have
24 specifically objected to. As you know, the
25 respondents in this case are employees of

1 Health Promotion Services, and Health Promotion
2 Services has been involved in civil litigation
3 with the South Carolina Dental Association and
4 actually at present has reached a settlement
5 where the Dental Association has agreed to pay
6 some settlement money as damages to HPS for
7 some unlawful activity which occurred in the
8 past. It is our information that Dr. Rawls,
9 with all due respect, that you have been a
10 Board member and an active member of the Dental
11 Association and Ms. Baker, that your employer
12 has as well, and we believe that due process
13 requires that we haven a panel that is
14 completely objective, not have any grounds for
15 bias against our clients, and we're seriously
16 concerned by virtue of the prior civil
17 experience and the existing damages liability
18 that's been assessed against the Dental
19 Association to the clients, that it's not going
20 to be possible for you all to be fair and
21 unbiased in addressing the issues before ...
22 before you and before the Board, and we would
23 ask that you Dr. Rawlins and you Ms. Baker
24 recuse yourselves from these proceedings.
25 MR. ROSEN: Let's see if Mr. Woodington has any

1 comments he would like to make.

2 MR. WOODINGTON: I don't know exactly how to address
3 that. I suppose that's the ... it's the
4 business of the particular members who've been
5 challenged to examine, you know, how you feel
6 about that and whether you think it is
7 appropriate to recuse yourself. I would point
8 out that these cases ... I believe all the
9 panel members have already seen the formal
10 accusations in these cases, is that correct?

11 MR. ROSEN: They have seen the two that were
12 scheduled for today; that's all they've seen,
13 they saw them this morning.

14 MR. WOODINGTON: Okay. Well, I don't want to jump
15 the gun, but in effect these are cases about
16 the standard of care by specific hygienists
17 with respect to specific patients. And I guess
18 the issue that I would ask each panel member to
19 consider is whether or not anything, any prior
20 dealings with HPS which is the employer of
21 these people, but is not the ... not the
22 respondent in these cases, would affect your
23 ability to have a fair hearing on the issue of
24 whether the standard of care was violated in
25 these particular cases. And to be honest with

1 you, I guess I would like a statement from each
2 Board member, or from these two Board members,
3 on the record about that, for the record, after
4 you all have had a chance to maybe discuss that
5 issue.

6 MR. ROSEN: If I may, my experience in the past when
7 we've had recusal issues that have come up,
8 typically what's taken place is there's been a,
9 what I would call a voir dire of the members at
10 issue, some questions that are asked by the
11 person who is seeking recusal, and as a result
12 of those questions, now I'm not talking about
13 a cross-examination of the members of the Board
14 and it's not under oath, but it is on the
15 record. As a result of those answers I think
16 we get some ... some clarity out of it. If you
17 don't want to proceed that way, that's fine.
18 I think the ultimate question is whether the
19 individuals involved feel that they can, in
20 light of what has been raised, whether they can
21 render a fair and unbiased opinion in this
22 case. I'm also of the opinion, some would
23 perhaps disagree with me that, though that is
24 initially a personal decision by the
25 individuals who's asked to recuse himself, it's

1 also possible for the majority of the panel or
2 the Board to recuse a member themselves, and
3 I've had that situation occur. One thing in
4 particular that might be of interest to me was
5 that, I believe you indicated that Dr. Rawls
6 and Ms. Baker's employer were members of the
7 ...

8 MS. BALLARD: Officers and/or Board members, past or
9 present members.

10 MR. ROSEN: Officers or board members of the Dental
11 Association.

12 MS. BALLARD: Correct.

13 MR. ROSEN: Is the timing of when they were Board
14 members?

15 MS. BALLARD: The litigation has gone on for quite
16 some years, and I don't have the exact years in
17 front of me. Perhaps Dr. Rawls or Ms. Baker
18 can enlighten us on that because I don't
19 honestly have that information. I can put up
20 a witness that can provide you with a history
21 of that litigation, but I think that's really
22 a collateral issue. If we look at ... equating
23 this to the standard under the Code of Judicial
24 Conduct, for instance, in order to assure a
25 defendant in a similar criminal matter that he

1 or she is receiving a fair trial, the standard
2 for determining whether recusal is appropriate
3 is the appearance of impropriety and not in
4 fact whether impropriety does in fact exist.
5 If reasonable people could believe that by
6 virtue of your professional associations or
7 your past experiences, that you would not be
8 completely unbiased, not what you believe but
9 what reasonable people would believe, that my
10 clients are entitled to have you recuse
11 yourself or to be recused so that they can have
12 confidence in the integrity of these
13 proceedings, that they are being in fact
14 adjudicated by a completely unbiased fact
15 finding body. And I would just again say that
16 we are not suggesting, Dr. Rawls, that you or
17 Ms. Baker hold any prejudices for these
18 clients, but because of the factual background
19 involving the litigation with the Dental
20 Association which was quite unpleasant, and
21 because of the existing obligation of the
22 Dental Association to pay financial retribution
23 to the HPS folks, the appearance of impropriety
24 certainly cannot be questioned. And we would
25 take the position that it would be impossible

1 for anyone appearing before a panel in which
2 sitting members, or past officer and members of
3 the Board and governing body of the Dental
4 Association, were sitting as adjudicators and
5 fact finders as to their professional licenses.
6 It would be impossible for them to believe that
7 they received an unbiased adjudication. The
8 appearance of impropriety is clearly present.

9 CHAIRMAN RAWLS: I'll speak to that first ...

10 MR. ROSEN: Well, I think Mr. Woodington has
11 something to say.

12 MR. WOODINGTON: Mr. Chairman, can I say one more
13 thing. I would submit that if she has grounds
14 for recusal, she needs to provide some proof of
15 that, other than ... either through voir dire
16 of the members themselves or some kind of
17 external proof and not just make allegations
18 that, you know, she's heard that you were on
19 the board of the Dental Association, at some
20 time or other there was a lawsuit and some
21 money was paid at some time or other. It's all
22 rather vague and ...

23 MS. BALLARD: I'll be happy to do that, but again I
24 don't think ... I don't want to get into a
25 collateral litigation over the issue of the

1 litigation between HPS and the Dental
2 Association. But I'll be happy to call a
3 witness to outline in detail the litigation; the
4 settlement amount as I understand it is
5 confidential, so we're not allowed to disclose
6 that particular amount, but funds are being
7 paid. I think Dr. Rawls and Ms. Baker are
8 fully capable of stating what their past and
9 present involvement with the Dental Association
10 has been without being put under oath. But
11 I'll be happy to call a witness regarding the
12 litigation. Would you like me to proceed with
13 that, Mr. Chairman?

14 CHAIRMAN RAWLS: I don't think we need to do that
15 just yet.

16 MS. BALLARD: Thank you, Mr. Chairman.

17 CHAIRMAN RAWLS: First of all, I was president of
18 the South Carolina Dental Association in 2003
19 to ... 2003, 2004 ... 2002, 2003, yes, during
20 which time this litigation was going on.
21 Actually, I was minimally involved in the
22 litigation. We had attorneys that were doing
23 that and nothing really substantive happened
24 during that time period, at least that I could
25 see as substantive. The suit named a couple of

1 specific individuals I recall, and then the
2 South Carolina Dental Association Board of
3 Governors as defendant, that changes from year
4 to year, who the South Carolina Dental
5 Association Board of Governors is. Actually,
6 you just ... the first time, I have no idea
7 what the outcome of the suit was because my
8 understanding was it was all confidential, and
9 when I asked about it it was always stated to
10 me as being confidential. To make a long story
11 short, I don't feel that I need to recuse
12 myself in these cases.

13 MS. BAKER: Yes, I am an employee of Dr. Tom Kays.
14 He was on the Board and I served as a deputy
15 examiner with the Board for the hygiene works
16 about ten years ago. I don't feel like I have
17 any bias, I'm was never aware of anything with
18 HPS, he never discussed any of that in front of
19 me. Everything he did was probably in his
20 office and away from me so, you know, I feel
21 like I don't need to recuse myself. I fell
22 like they might want a dental hygienist on the
23 panel.

24 CHAIRMAN RAWLS: I'd like to ask if the other members
25 of the Board think there's grounds for us to

1 recuse ourselves. Do you have any ideas on
2 that? Without prejudice by me ...

3 MR. ROSEN: You may want to go into executive session
4 now.

5 DR. COOMBS: I'll move that we go to executive
6 session.

7 MS. BALLARD: If we're going to do that, if I could I
8 would ask too, if any of the Board members have
9 taken any public statements opposing the
10 presence of dental hygienists in schools, that
11 would be an issue that of course is central to
12 this litigation and we would also ask for you
13 to consider that issue as well.

14 CHAIRMAN ROSEN: Do we need any response from the
15 other three members as to that issue?

16 DR. COOMBS: Do we need ... I mean, I can speak to
17 that. I have not made any public expression to
18 the presence of hygienists in the public school
19 system.

20 MS. BALLARD: Thank you, Dr. Coombs.

21 DR. JETT: Nor have I.

22 MS. BALLARD: Thank you, Dr. Jett.

23 DR. WADE: I have not made any.

24 MS. BALLARD: Thank you, Dr. Wade.

25 CHAIRMAN RAWLS: Okay, a motion to go into executive

1 session?

2 DR. COOMBS: I'll move.

3 DR. WADE: I'll second.

4 CHAIRMAN RAWLS: All in favor, aye.

5 ALL: Aye.

6 CHAIRMAN RAWLS: We'll go in there again.

7 MS. BALLARD: Thank you.

8 (Executive session, 11:15 a.m. to 11:19 a.m.)

9 CHAIRMAN RAWLS: We will proceed. First do I hear a
10 motion to come out of executive session?

11 DR. COOMBS: I make a motion.

12 CHAIRMAN RAWLS: Motion's made.

13 DR. WADE: Second.

14 CHAIRMAN RAWLS: Seconded. All in favor say aye.

15 ALL: Aye.

16 CHAIRMAN RAWLS: Do I hear a motion considering ...
17 concerning the issue at hand?

18 DR. COOMBS: I move that the request for the recusal
19 of Dr. Rawls and Ms. Baker be denied.

20 DR. JETT: I second it.

21 CHAIRMAN RAWLS: Motion's made and seconded. All in
22 favor say aye.

23 ALL: Aye.

24 CHAIRMAN RAWLS: We'll not be recused from these
25 matters.

1 MR. COLEMAN: May I just ask, with all due respect to
2 Dr. Rawls, if we may ask several more questions
3 which arose. During the break it was brought
4 to our attention that during the time period
5 that you were present at the Dental
6 Association, that the Association did take a
7 position against hygienists into ... in the
8 school system, is that correct?

9 CHAIRMAN RAWLS: I don't believe that's correct; I
10 don't recall that. In fact, my ... during that
11 year my, what do you call it, access to care
12 was my thing for that year. I don't recall
13 during that time period objecting ... that
14 hygienists in the schools was an issue at all.

15 MR. COLEMAN: I think there were some articles
16 published in the Dental Association magazine
17 where I think that the Dental Board took a
18 position ...

19 MS. BALLARD: The Dental Association.

20 DR. COOMBS: ... Dental Association, if you were
21 aware of that, if you participated in that?

22 CHAIRMAN RAWLS: You'll have to show those to me. I
23 know I didn't ... didn't object to hygienists
24 in the schools.

25 MR. COLEMAN: As it relates to this particular

1 company, have you ever made a public comment
2 about the company that these hygienists worked
3 for, pro or con?

4 CHAIRMAN RAWLS: I don't recall having made a public
5 statement one way or the other.

6 MR. COLEMAN: Thank you.

7 MR. WOODINGTON: Just to protect the record, Mr.
8 Chairman, could I ask one question of each of
9 the two of you?

10 CHAIRMAN RAWLS: (Nods head affirmatively.)

11 MR. WOODINGTON: And that is, as you know, this
12 panel's job is to make a recommendation of the
13 dental Board as I understand it, follow the
14 same procedure as the medical board panels.
15 Would your recommendation, any recommendation
16 that you join in about this case, be based only
17 on the evidence that's presented in this
18 hearing today, as Ms. Baker's indicating?

19 MS. BAKER: Yes, and that's it.

20 CHAIRMAN RAWLS: Any other issues?

21 MS. BALLARD: A much easier one. As you know we have
22 four different cases, and both sides, Mr.
23 Woodington and I discussed this with Mr. Rosen,
24 we have a number of witnesses that will talk
25 about the standard of care and the history of

1 the involvement of sealants in the school
2 programs, the hygienists in the school
3 programs. It didn't make sense to us, when Mr.
4 Woodington and I discussed this, to present
5 those same witnesses in each of the four cases.
6 So what we decided was that we would present
7 them in the initial case for Anonymous No. 1
8 and ask to have the testimony from those
9 witnesses on the general issues that are
10 applicable to all four cases incorporated by
11 reference, so that you won't have to listen to
12 the same witnesses four times talk about the
13 same issues four times. That will necessitate
14 some blending of the record, but I think in the
15 sake of judicial economy if nothing else, that
16 would be our preference if the panel has no
17 objection to actually doing that. So we would
18 have certain witnesses who would testify in
19 Anonymous No. 1's hearing who would not
20 physically testify in the other hearings, but
21 their testimony would be included in those.
22 Did I state that correctly, Ken?

23 MR. WOODINGTON: Mr. Chairman, we have no objection
24 to that procedure. What we would like to do
25 for each expert is have the expert, such as Dr.

1 Sneed, give a general presentation in the first
2 case, and then apply his presentation in a much
3 shorter testimony to all the succeeding cases.
4 So say if he was a half an hour long in the
5 first case, he might be ten minutes in every
6 succeeding case.

7 MS. BALLARD: And we would do the same with Dr.
8 Simonsen as well.

9 CHAIRMAN RAWLS: I think that would be acceptable.

10 MS. BALLARD: The Respondent has nothing further as a
11 preliminary matter. Thank you.

12 CHAIRMAN RAWLS: Again, I know that this has been
13 happening but I would request that all remarks
14 be addressed to the Chairman. At this point,
15 we would ask for opening comments by the State.

16 MR. WOODINGTON: Thank you, Mr. Chairman, and I
17 appreciate the panel's patience with us as we
18 marked exhibits this morning, I think it would
19 make this go more quickly in the long run. And
20 with that, the case ... this is the Anonymous
21 No. 1 case, and the formal accusation states
22 that on two instances this particular
23 Respondent placed sealants over four teeth, and
24 eight teeth respectively on two different
25 patients, and that the examining dentist whom

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1 I'll call in a minute, Dr. Chadwick, found that
2 in some cases sealant have been placed over
3 gross caries on those teeth. These are simple
4 cases, Mr. Chairman and members of the panel,
5 I would submit. It's strictly a standard of
6 care issue. We are going to call the examining
7 dentist to testify that he examined the
8 patients, usually after sealants were applied,
9 but in one or two cases before sealants were
10 applied, and that based on his examination he
11 found that the sealants had been placed over
12 gross caries and that the hygienist should have
13 been able to see that at the time that the
14 patients presented. All these patients of
15 course are public health, are school children
16 getting these services in the public health
17 dentistry program in the public schools. There
18 is no issue in these cases, I want to be very
19 clear about this, there is no issue about
20 whether sealants should or could be placed as
21 a general matter over sound teeth or even in
22 teeth with possible incipient decay. That's
23 not the issue before you this morning. The
24 question is whether sealant should be placed
25 over gross frankly cavitated surfaces. Also an

1 issue that's been much debated in this area in
2 public for some time, is whether or not a pre-
3 examination by a dentist is necessary before a
4 hygienist can do much of anything in the public
5 health program; that is not an issue we're
6 raising either. It's our position that these
7 hygienists were in the public schools pursuant
8 to law, they were examining these patients
9 pursuant to law; it's just that they failed in
10 the execution, in their ... in helping these
11 patients and that their treatment fell below
12 the standard of care in these specific cases.
13 Again, we're going to call the examining
14 dentist in each case. And in one case we'll
15 probably call the hygienist who is employed by
16 the dentist as well, and in fact in this case,
17 the Anonymous No. 1 case, then we'll call Dr.
18 Sneed of the MUSC dentistry department who will
19 testify about his opinion about the propriety
20 of placing sealants under the facts of each
21 particular case, and in general for that
22 matter. As I understand it from just our
23 discussion a minute ago, this Board, this
24 panel's job is to recommend a resolution of
25 this matter to the full dental Board. I think

1 this is the first time we've ever had a panel
2 in a dental Board case, so you're sort of
3 treading new ground if that's the case, but the
4 outcome of this proceeding would be a
5 recommendation by this panel to the dental
6 Board about whether the standard of care was
7 violated or whether the standard of care was
8 not violated. If you follow the medical board
9 proceedings and find that there was a
10 violation, then you go on and recommend that a
11 sanction be issued. Medical board panels, as
12 I understand it, don't recommend what that
13 sanction should be, they just recommend that a
14 sanction should be issued. And the reason for
15 me saying all that is that we submit that when
16 the evidence is presented, your result in this
17 case should be that the standard of care was
18 violated and that you should recommend to the
19 dental Board, the full dental Board, that a
20 sanction should be issued in this case. I'll
21 be happy to answer any questions and then put
22 up the evidence after the other side has
23 finished.

24 CHAIRMAN RAWLS: Ms. Ballard?

25 MS. BALLARD: Thank you very much, Mr. Chairman. Mr.

1 Woodington would like this to be a simple case,
2 but unfortunately it's not. It's impossible
3 for the Dental Board to look at this case in a
4 vacuum, and it is critical in fact that
5 practice area issues be addressed in looking at
6 the allegations that there was a deviation from
7 the standard of care in these four cases.
8 These patients were seen in the context of a
9 hygienist program in the public schools which
10 is administered under the authority of the
11 Department of Health and Environment Control.
12 These patients were not seen in a private
13 practice setting. In looking at the issues, it
14 is critical that this panel and the Board be
15 aware of the history of the Dental Board's
16 active opposition to the presence of school-
17 based dental hygienist programs. Without
18 objection we have introduced into the record,
19 I'll hand up a copy of an order of the Federal
20 Trade Commission where the Federal Trade
21 Commission has actually sued the Dental Board,
22 the South Carolina Dental Board, on the basis
23 of anti-trust for trying to put the dental
24 hygienists out of business. That matter is
25 currently on appeal to the Fourth Circuit, but

1 the order itself very, very graphically details
2 the active struggle of the South Carolina
3 Dental Board to put the HPS program and the
4 school-based hygienist programs out of
5 business. We believe that these disciplinary
6 charges against these four hygienists are
7 simply the next step in that process. The
8 Dental Hygienist school-based program has been
9 immensely successful; you'll hear testimony
10 about the number of children who have seen
11 dentists for the first time in their lives in
12 rural counties around the state, who have never
13 seen dentists before, who now have been
14 educated regarding the proper care of teeth,
15 and have sealants applied and who are going to
16 be much, much better off in fighting caries as
17 a result of that. There is naturally, as the
18 Dental Board has obviously noticed, some
19 economic dichotomy between a successful school-
20 based program and Dental Board members who are
21 in private practice. If children don't get
22 filling ... don't get cavities, they don't go
23 see dentists. So there has been an active
24 effort on our part, on the part of the Dental
25 Board to put this program out of business.

1 With that in mind, it is about the standard of
2 care in the public school setting and what is
3 appropriate in terms of sealants. I listened
4 very carefully to Mr. Woodington's
5 presentation. He indicated to you that it is
6 their position that it was a deviation from the
7 standard of care to place sealants over, as he
8 described it, gross caries. First of all, we
9 don't believe you'll find evidence of that.
10 But secondly, he didn't say a word, not one
11 word, that a single student suffered an injury
12 or damage, or any harm whatsoever occurred to
13 any these students. We will present testimony
14 from Dr. Richard Simonsen, who is here today,
15 who is, from all ... everything I've seen, the
16 world's foremost authority on the issue of
17 preventative dentistry and dental sealants.
18 And he has looked at the records in these
19 cases, he will testify in these cases, and he
20 will say not only does the school program do
21 exactly what it's supposed to do, which is to
22 get children to dentists, but that these
23 hygienists acted fully within the scope of
24 proper dental hygiene and provided protection
25 for the teeth of these students. Dr.

1 Simonsen's testimony will be that the placing
2 of sealants on teeth, whether incipient or even
3 gross caries, certainly causes no damage and at
4 a minimum arrests the caries in the tooth and
5 prevents it from growing further. So worst
6 case scenario, if my clients did everything
7 that they're alleged to have done, their only
8 crime is having helped these children stop
9 caries development in their mouths. And there
10 is a philosophical issue that has to be front
11 and center when you're looking at these issues,
12 as to whether or not this program does what it
13 is supposed to do. You'll see evidence in each
14 of these cases that these children hadn't seen
15 dentists, in fact ended up in the offices of
16 dentists and that's why we have complaints. We
17 got these children to dentists, they got dental
18 care, and we have disciplinary charges brought
19 against us for having done that. That's simply
20 not appropriate. I will hand up two exhibits
21 which have been introduced into evidence
22 without objection. One is Respondent's Exhibit
23 Number One, which is the Order and Opinion of
24 the Commission, the Federal Trade Commission,
25 finding that the Dental Board engaged in

1 improper activity in attempting to put the
2 hygienists out of business ...

3 MR. ROSEN: I think there may be an objection.

4 MR. WOODINGTON: I don't object to her presenting it
5 when her turn comes, but it's not her turn yet.

6 MS. BALLARD: It's part of my opening statement
7 that's been introduced without objection.

8 MR. ROSEN: I really do think that it would probably
9 unfold more easily in the Board's mind, excuse
10 me, the panel's mind, if it was part of your
11 presentation in chief.

12 MS. BALLARD: This is my presentation in chief. This
13 is opening statement. Is there any harm in
14 introducing it at this point? It's already
15 been introduced.

16 MR. ROSEN: Well, it just ... it just seems to me a
17 little out of order.

18 MS. BALLARD: Is that a ruling?

19 CHAIRMAN RAWLS: This is just for brief opening
20 statements, later you'll be able to present
21 your case.

22 MS. BALLARD: All right, I'll be happy to do that. I
23 would like for the record to indicate though
24 that these matters are already in evidence.

25 CHAIRMAN RAWLS: Are what on evidence?

1 MS. BALLARD: In evidence.

2 MR. WOODINGTON: Just for the record, we've stipulated
3 I think that our Exhibits One through Eight and
4 her Exhibits are all in evidence ...

5 MS. BALLARD: That's correct.

6 MR. WOODINGTON: If that's acceptable to the Chairman.

7 CHAIRMAN RAWLS: Sure. Mr. Woodington, I assume you
8 are ready to present your case, to present your
9 exhibits?

10 MR. WOODINGTON: Thank you, Mr. Chairman. Let me
11 just, if I may, hand up the Exhibits and let
12 you all distribute them. I assume that's okay?

13 MS. BALLARD: No problem.

14 MR. WOODINGTON: They've already been marked, the
15 original's have been marked. Dr. Sneed we will
16 call second, this is his CV, our Exhibit One.
17 Exhibit Two is the patient chart of Dr.
18 Chadwick.

19 MS. BALLARD: I'm having a little trouble hearing
20 you, Ken, I'm sorry.

21 MR. WOODINGTON: This is the ... this is the patient
22 chart, Number Two is the patient chart of a
23 patient named M.A. that Dr. Chadwick will
24 testify about.

25 MS. BALLARD: Are you also introducing the HPS Chart?

1 MR. WOODINGTON: Yes. Exhibit Three is some
2 photographs. I could do this as ... as the
3 witness gets to them, but I think it's just
4 easier to hand them all out.

5 MS. BALLARD: And I have no objection to that. I
6 just wanted to know what we were receiving.

7 MR. WOODINGTON: The color photos taken in Dr.
8 Chadwick's office of this patient M.A..

9 MS. BALLARD: And for the record, you are
10 distributing Exhibit Number what?

11 MR. WOODINGTON: Three.

12 MS. BALLARD: There were others. One, Two, and
13 Three?

14 MR. WOODINGTON: One, Two, and Three so far. I'm not
15 through yet. Four is the HPS records for that
16 same patient, M.A. Five is a letter from
17 Anonymous No. 1, the hygienist in this matter,
18 the Respondent, with a copy of a hand-written
19 note that she had affixed to it. Number Six,
20 we get into a different patient, same
21 hygienist, T.M.

22 MS. BALLARD: I'm sorry, I'm having trouble hearing
23 you.

24 MR. WOODINGTON: This is the HPS chart for T.M.
25 This is the other patient. There are two

1 patients involved in this case. And lastly,
2 well next to the last, Number Seven is Dr.
3 Chadwick's, the pertinent pages of Dr.
4 Chadwick's chart for T.M..

5 MS. BALLARD: Have you given the court reporter
6 copies of those?

7 MR. WOODINGTON: She'll get the originals.

8 MS. BALLARD: Okay.

9 MR. WOODINGTON: And the last one, which I don't have
10 copies of is the exhibit, I mean, the x-ray of
11 T.M., which may or may not come in, I don't
12 know yet. That's where we are. Now we call Dr.
13 Stephen Chadwick. If the panel members are
14 ready, I'll proceed.

15 STEPHEN C. CHADWICK, D.M.D., having been duly sworn,
16 testifies as follows:

17 DR. CHADWICK - DIRECT EXAMINATION BY MR. WOODINGTON:

18 Q: Dr. Chadwick, could you state your full name,
19 please.

20 A: Stephen Christopher Chadwick.

21 Q: Okay. And Dr. Chadwick, I'm going to be a
22 little bit loud because I understand you have
23 a cochlear implant; is that correct?

24 A: That's correct.

25 Q: If you can't hear me or can't hear anybody

1 else, please ask me to speak up.

2 A: I'll let you know.

3 Q: Thank you. What's your address?

4 A: Work address or home?

5 Q: Work address.

6 A: Work is 1818 Remount Road, Hanahan, South
7 Carolina.

8 Q: Are you a practicing dentist?

9 A: Yes.

10 Q: What's your field of practice?

11 A: I'm a general dentist.

12 Q: General dentist? Could you state your
13 educational background for us?

14 A: Sure. I graduated from Salisbury State
15 University in Maryland with a degree in
16 biology and a minor in chemistry. I went to
17 the Medical University of South Carolina ...

18 MS. BALLARD: Can I interrupt for a second? Is there
19 a microphone or something that we can use to
20 help the acoustics? Okay. That's all right.

21 A: Do you want me to talk louder?

22 Q: Yes, please.

23 MS. BALLARD: Yes, please talk louder.

24 Q: Let me come over here and that way if I can
25 hear you, the panel can hear you.

1 MS. BALLARD: And I'll speak up if we're having a
2 problem back here.
3 A: Okay. No problem. I'll talk louder.
4 Q: Okay. Yeah, please.
5 A: I don't like to be one of those deaf people who
6 talks too loud.
7 MS. BALLARD: I understand. Consider that not a
8 problem here.
9 Q: Okay. I think you were through with Salisbury
10 State.
11 A: Right. I went to Salisbury State University in
12 Salisbury, Maryland. I got a BS degree in
13 biology, a minor in chemistry. I went to the
14 Medical University of South Carolina and
15 graduated in 1994 with my DMD degree.
16 Q: Okay.
17 A: And I've been in practice since 1994.
18 Q: Have you been in practice in Hanahan all that
19 time?
20 A: No. I started out in Spartanburg and wound up
21 back in Charleston after five years.
22 Q: Have you been in general dental practice since
23 1994?
24 A: No, I was in a denture practice when I
25 originally started. I've been doing general

1 dentistry again for five years.

2 Q: Okay. Are you here under subpoena?

3 A: Yes, I guess I am.

4 Q: Okay.

5 MR. WOODINGTON: We would offer Dr. Chadwick as a
6 expert in the field of general dentistry, which
7 includes of course, the diagnosis and treatment
8 of tooth decay.

9 CHAIRMAN RAWLS: We'll accept that.

10 MS. BALLARD: I'm sorry. Would you repeat the field
11 in which he's being qualified?

12 MR. WOODINGTON: General dentistry ... general
13 dentistry including the diagnosis and treatment
14 of tooth decay.

15 MS. BALLARD: No objection.

16 Q: Dr. Chadwick, was T.M. and M.A. patients of
17 yours at one time?

18 A: Say that one more time, I'm sorry.

19 Q: Were T.M. and M.A. patients of yours?

20 A: Yes.

21 Q: And let me show you Petitioner's Exhibit Two,
22 which is the M.A. chart, I believe. Could you
23 just ... because your handwriting is frankly
24 hard to read, could you please describe the
25 first event on that chart, which I think is

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1 5/8/03.

2 MS. BALLARD: Let me make sure I get to it before you
3 start, if you don't mind. Is this Exhibit
4 Number Three?

5 MR. WOODINGTON: Two.

6 MS. BALLARD: Thank you. Again, I'm sorry.

7 A: Okay. 5/8/03, she was seen by my hygienist
8 which would have been Caty Way, and she had a
9 new patient exam and a prophylaxis, light to
10 moderate gumline plaque, and light
11 interproximal tartar present, polished,
12 flossed, and took Pan and two bite wings. Then
13 the last part of it says six months was the
14 next recall.

15 Q: Is that her handwriting or your handwriting,
16 Doctor?

17 A: That's her handwriting.

18 Q: Okay.

19 A: It's my initials beside it because I do an exam
20 at the same time.

21 Q: Okay. Is the next entry also on that same day?

22 A: Yes. We in general try very hard, especially
23 with Medicaid children, to see them on the same
24 day if possible. And then we did, as you can
25 see, I did drill fillings on one side of the

1 mouth.

2 Q: I'm sorry. I didn't hear that.

3 A: We did a lot of fillings. That's what all that
4 is.

5 Q: Can you describe what that means? I'm at a
6 loss to understand.

7 A: Okay. All right. We did ... it looks as
8 though we did about twelve fillings on one side
9 of her mouth ...

10 Q: Okay.

11 A: ... on that particular day.

12 Q: Okay. How about describing to me, because
13 sooner or later this may be reviewed by non-
14 dental people.

15 A: Right.

16 Q: The tooth numbers are in the lefthand column,
17 I think, correct?

18 A: That's exactly right.

19 Q: And then the, in the column that says surface,
20 could you describe what your abbreviations are
21 there?

22 A: Right. Occlusal, buccal, lingual. Occlusal is
23 the top surface where you chew, what you tap up
24 against the opposing teeth. Buccal is towards
25 the cheek. Lingual is ... that's towards the

1 tongue. And we don't have mesial and distal on
2 here, but mesial would be towards the front of
3 the mouth and distal towards the back.

4 Q: Okay. What do your notes say there? It looks
5 it says RHH or something.

6 A: Okay. Reviewed health history, gave her three
7 carpules of lidocaine and we filled the teeth
8 with a Tetric Flow composite and we used L-Pop
9 as our binding and etching.

10 Q: Okay. What's the next treatment there on
11 5/29/03?

12 A: 5/29, she came back in for the other half of
13 her mouth. So we did, in essence, I think
14 about twenty-four fillings it looks like here.

15 Q: Are these all permanent teeth that the fillings
16 were done on?

17 A: All permanent teeth, all posterior teeth.

18 Q: I'm sorry, I didn't hear the last answer.

19 A: All posterior teeth. All the back teeth.

20 Q: Okay. Let me show you Petitioner's Exhibit
21 Three, or at least a copy of Petitioner's
22 Exhibit Three, and that's a series of color
23 photos. Using those and the chart as necessary
24 to refresh your recollection ...

25 MS. BALLARD: Could we just identify that these were

1 in fact taken by him or that he's familiar with
2 what they are?

3 MR. WOODINGTON: Oh, I'm sorry.

4 Q: Go ahead. Are you familiar with these
5 photographs?

6 A: Yes, they're mine.

7 Q: Did you take these yourself?

8 A: My hygienist took them.

9 Q: Okay. But are they part of your records?

10 A: Yes.

11 Q: Part of your office records? Have you reviewed
12 these photographs?

13 A: Yes.

14 Q: Okay. Do they accurately describe what you saw
15 when you looked in the mouth of this patient on
16 that day?

17 A: Right, only a little bit more in focus.

18 Q: Now, do you remember which day those taken on?
19 Can you tell that from either the photographs
20 or your records?

21 A: What date they were taken on?

22 Q: Correct.

23 A: 5/8/02, '03.

24 Q: '03, okay.

25 A: It's got the date down at the bottom left of

1 the picture.

2 Q: So it is. I'm sorry. Okay. And I think
3 there's a number after 5/8/03. Is there a
4 number by each one? And that's the number of
5 the tooth that's depicted; is that correct?

6 A: I believe that's correct.

7 Q: Okay. Let's just go through these pictures one
8 by one and what I want to ask you is ... first
9 of all, were sealants in place on all these
10 teeth on 5/8/03 when you saw this patient?

11 A: I believe so.

12 Q: All the teeth ...

13 A: Certainly on all the molars.

14 Q: All the molars. And the molars are what are
15 depicted in these pictures?

16 A: Yes.

17 Q: Okay. Going through each one, one at a time,
18 can you tell me what you were able to, and tell
19 the panel, what you were able to observe about
20 decay from those, from examining those teeth in
21 that condition?

22 A: Okay. In this first photo that's labeled 02,
23 we can see that ...

24 MS. BALLARD: I'm sorry. I don't have an 02. The
25 first one I have is an 03.

1 MR. WOODINGTON: I've got 02 right here.

2 MS. BALLARD: Yeah. I know where the numbers are, I

3 wasn't given an 02. Can I just look over your

4 shoulder?

5 A: Sure. You can do that.

6 MR. WOODINGTON: It's the last one.

7 A: We've got a sealant ...

8 Q: Hold on.

9 MS. BALLARD: I've got it.

10 MR. WOODINGTON: Okay. Does everyone have the one

11 that says 02 down in the lower left?

12 Q: Okay. Go ahead.

13 A: We have a sealant that's sort of placed on the

14 OB surface but it doesn't really fully extend,

15 you know, it's not a complete sealant. And

16 then the OL is not, apparently is not sealed.

17 Q: Who?

18 A: OL, the groove at the top.

19 Q: That's okay. To what extent is decay present

20 on that tooth as far as you can tell from that?

21 A: Well, I'd say that one, you know, it looks

22 decayed to me, but it's not as clear as some of

23 the other ones.

24 Q: Okay. Let's keep going then. Move onto the

25 next one.

1 A: This next picture to me is a lot more clear.
2 Q: Which one is that?
3 A: The one labeled 03.
4 Q: 03. Bear with me a second.
5 A: Mine must be in a different order, sorry.
6 Q: Okay. I have 03.
7 A: Okay. And you can see again only one of the
8 grooves seems to be sealed and the other one
9 doesn't look so good.
10 Q: What is the decay condition of that tooth?
11 A: Well, I'd say this is ... throughout almost all
12 of these there was gross caries.
13 Q: Was it apparent with this picture?
14 A: Visually.
15 Q: Visually. And what did you look at to see that
16 it was apparent, to see that decay was
17 apparent?
18 A: The decay was what?
19 Q: Apparent.
20 A: Oh, yeah, sure.
21 Q: No. I mean, what did you look at? What told
22 you that?
23 A: Well, you can see through the enamel,
24 especially in one of the later pictures, you
25 can really see the darkness underneath the

1 enamel. The grooves can be stained like this,
2 but now with an explorer, you know, you can
3 feel the stickiness of teeth. That's how we
4 detect decay a lot. And also visually, you
5 know, you can just see that they're decayed.
6 You see enough of it and you're quite used to
7 seeing it and you know what it looks like.

8 Q: Okay.

9 A: But like I say, you know, in some of these
10 pictures it becomes a lot more apparent. And
11 then when we removed the sealants it was, you
12 know, very apparent that we were removing gross
13 decay.

14 Q: When you removed the sealants, did you get the
15 teeth to the level that they were before the
16 sealants were placed or did you, for a lack of
17 a better term, blow right through the sealants
18 and get lower than that at the same time?

19 A: We probably would have just removed the
20 sealants because of what we saw. I mean, we
21 did not remove the sealants to look at the
22 tooth underneath, but just to take out what we
23 saw that was not done very well.

24 Q: Okay. Let's move on to your next picture, the
25 next one you want to tell us about.

- 1 A: I've got fourteen. What do you have?
- 2 Q: Fourteen is fine.
- 3 A: Again, you know, this one looks a little better
- 4 than the other ones that we've looked at. You
- 5 can see the seal doesn't really go off all the
- 6 way to the right side of the picture into the
- 7 lingual groove, and then there's open fissures
- 8 in the lower part of the back tooth.
- 9 Q: Okay. Next tooth?
- 10 A: Same thing here.
- 11 Q: Which one, I'm sorry?
- 12 A: This is fifteen. Same thing here, you know,
- 13 partly sealed and caries.
- 14 Q: I'm sorry. Would you call that gross decay on
- 15 that tooth?
- 16 A: You know, it was.
- 17 Q: Could you tell whether the decay that's still
- 18 visible on this tooth extends into the dentin?
- 19 A: Yes, it was ... it's very visible. I, you
- 20 know, I'm not ... I bet you Dr. Sneed could
- 21 tell you from looking at that if it was down to
- 22 the gum, but I just, you know, I go more by
- 23 feel. I use a Diagnodent. I use a laser to
- 24 help me see how deep the decay extends, it
- 25 gives me a numerical value; and I use my

1 explorer; and I use my eyes. So I use a lot
2 different things to diagnose decay.

3 Q: How much of that is available ... do you know
4 how much of that is available to a dental
5 hygienist who ...

6 A: Yeah. The a dental hygienist?

7 Q: Right.

8 A: Everything I've described.

9 Q: Okay.

10 A: You can use an explorer; you can use your eyes;
11 you can use a Diagnodent, because none of it
12 involves removing tooth structure.

13 Q: Okay. Did you say laser also?

14 A: Huh?

15 Q: Did you say laser also?

16 A: No, laser is a diagnodent.

17 Q: Okay.

18 A: I'm using dental terms and I just slip into
19 another language.

20 Q: Okay.

21 A: But the laser causes the bacteria to fluoresce
22 and it gives a numerical value based on the
23 number of bacteria present. And I use it
24 pretty extensively in my office to evaluate
25 decay.

1 Q: Okay. How about ...

2 A: A lot of it is eyes, okay? That's, you know
3 ... I'm sorry. We just looked at these and why
4 did they seal these teeth. That's sort of
5 where we were coming from. The best example to
6 me is the one labeled 31. I mean, that tooth,
7 you know, you can see right through the enamel
8 and you can see the dentin and the dark. I
9 mean, it's a really bad tooth. That's the best
10 example that I have.

11 Q: Well, to put it in dental terms or lay terms,
12 as the case maybe, 31 is that what you would
13 call decay extending into the ...

14 A: That's gross decay.

15 Q: Gross decay.

16 A: Right.

17 Q: Does it extend into the dentin as far as you
18 can tell?

19 A: Right.

20 Q: Okay. How about 19?

21 A: It looks, it looks very similar. It's
22 obviously ... you know, you can just look even
23 not knowing anything about dentistry, it's
24 black. It's not supposed to be black. And
25 these aren't even ... some of these aren't even

1 near the grooves where there could be staining
2 just from cigarettes or ... well, not in kids.
3 But, you know, kids get stains as well from
4 soda and the like.

5 Q: Okay.

6 A: Some of this, you know, just looking at the
7 pictures and saying, no, it could just be
8 stained by ... and when you hit it with the
9 explorer you know the difference.

10 Q: For every tooth that you said had decay on it
11 so far that we've run down, was your ...
12 obviously you're looking at it right now with
13 the sealant present.

14 A: Right.

15 Q: Did you find gross decay when the sealant was
16 removed?

17 A: I found a lot of decay.

18 Q: Okay.

19 A: All of these teeth have decay..

20 Q: Okay.

21 A: Basically every permanent tooth from the canine
22 back, well behind the canine, are decayed.

23 Q: Okay. And they have ...

24 A: Gross decay.

25 Q: Okay. Did you make a recommendation to the

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1 parents of this child, M.A. ...

2 A: We told the parent that the child really needed
3 to have a lot of fillings. And we offered her,
4 you know, we told her that we would be happy to
5 do it for her. Of course mom was rather
6 surprised to find out that her child needed
7 fillings. I don't want to lie. There were two
8 different parents. One of them came because,
9 because ... she said they needed to ...

10 MS. BALLARD: I would object to the hearsay, insofar
11 as he's attempting to testify as to what the
12 parents said when they were visiting his
13 office. That would be inadmissible in the
14 hearsay rules.

15 MR. WOODINGTON: I'll buy that.

16 Q: Did you see the HPS chart when the person came
17 in, when M.A. came in? I'll show it to you and
18 ask you. It's Petitioner's Exhibit Four. Let
19 me ask you if you're familiar with that,
20 whether you saw it or not. Have you seen that
21 one ... did the parent bring that in with them?

22 A: I'm going to say no, I've never seen it.

23 Q: All right. Just for the panel's information,
24 I don't think that there's any issue that
25 Anonymous No. 1 applied these sealants, but I

1 think it's shown by Exhibit Four and also by
2 Anonymous No. 1's letter which is our Exhibit
3 Five, letter of September 11th of 2004, that
4 Anonymous No. 1 is actually the person who
5 applied the sealants in this case. Just
6 pointing that out from exhibits that are in the
7 records without objection. Okay. Did you find
8 out at the time ... when the patient came in,
9 did you find out who applied the sealants?

10 A: No, I don't believe so. I knew that we were
11 told she had them done at the school. The
12 particular hygienist, no, we didn't know.

13 Q: Okay, you didn't know. Were you ever ... did
14 the hygienist who placed the sealants ever call
15 you subsequently to this? Did you ever have
16 any conversation with the hygienist who placed
17 the sealants?

18 A: Yes, I believe so. She called and wanted to
19 talk to me. I can't remember the timing
20 exactly, but she called and told me that she
21 was doing the best she could and ...

22 Q: Okay. You don't need to go into what she said.
23 I don't think.

24 A: Right. It's hearsay again, sorry.

25 Q: Did she ... was this after you'd done the

1 restorations?

2 A: Yes.

3 Q: Okay. All right. Let's go back to your
4 original chart here for a minute if I can find
5 it.

6 MS. BALLARD: I think Plaintiff's Two.

7 Q: I don't know if there's anything relevant. Can
8 you tell the panel whether there's anything
9 relevant about March 11th, '04 when she came
10 back? I don't know if there is or not.

11 A: Right. Nothing really in particular. There
12 was no new decay.

13 Q: Okay. Let's look at the next chart which is
14 T.M. I think we're down to Number ... it's the
15 T.M. chart and I'll ask you if you can identify
16 it.

17 MS. BALLARD: What's the exhibit number, please?

18 MR. WOODINGTON: Seven.

19 MS. BALLARD: Seven.

20 Q: Okay. Same drill as before. Could you tell us
21 what the first entry on that is?

22 A: Okay. Again, this is ... my hygienist Caty
23 reviewed the health history, new patient exam,
24 prophylaxis, light gum line plaque, polish, floss,
25 Panorex, two bite wings, oh, fluoride. Okay.

- 1 Six months recall.
- 2 Q: And what did ...
- 3 A: And then she ...
- 4 Q: What's the next entry?
- 5 A: ... came back in and she saw my partner, Dr.
- 6 Coleman, because this is his handwriting.
- 7 Q: Okay.
- 8 A: At which point he filled a lot of primary teeth
- 9 and permanent teeth, one permanent tooth,
- 10 number three.
- 11 Q: Okay. So that's your partner that did those
- 12 fillings? Did you look at these teeth at all,
- 13 this patient?
- 14 A: I did her initial examination.
- 15 Q: Okay. Did you observe gross decay on the teeth
- 16 of this patient?
- 17 A: Yes.
- 18 Q: Did you observe gross decay that had been
- 19 covered with sealants on the teeth of this
- 20 patient?
- 21 A: Yes.
- 22 Q: Would it refresh your recollection to look at
- 23 an x-ray of the film that was taken by your
- 24 office?
- 25 A: Right.

1 Q: I'm going to show you Petitioner's Number
2 Eight, which is the T.M. x-ray. You can tell
3 the panel about the date of it.
4 MR. WOODINGTON: I'll have to pass this one around
5 because we don't have copies.
6 Q: What's the date on that?
7 A: 2/19/04.
8 Q: Okay.
9 A: Same date as the documentation in the chart.
10 Q: And that was taken in your office?
11 A: Yes, it was.
12 Q: And what does that show?
13 A: Decay, especially in the upper left, number
14 three, there's a good occlusion in there and
15 then we have, we have some decay on the rest of
16 the teeth as well, but the biggest one is
17 number three.
18 Q: Okay. And that ... was that tooth sealed at
19 that time when that picture was taken?
20 A: Yes, sir. I believe so.
21 MR. WOODINGTON: I'll just pass this around with the
22 envelope.
23 MS. BALLARD: Does that have a sticker number on it,
24 Ken?
25 MR. WOODINGTON: No.

1 MS. BALLARD: How are we going to keep that
2 identified?

3 MR. WOODINGTON: It's on the envelope.

4 MS. BALLARD: I know, but how are we going to keep it
5 identified ... it's on the envelope, okay.

6 A: That's actually a copy of the original.

7 Q: Okay. Looking back at your chart again, do you
8 know who placed the sealants on this ... do you
9 know of your own knowledge how these sealants
10 got placed?

11 A: Say that one more time.

12 Q: Do you know of your own knowledge who placed
13 these particular sealants?

14 A: Right. Okay.

15 Q: Do you know who placed the sealants?

16 A: They were done at school and we subsequently
17 found out that it was this group.

18 Q: Okay.

19 MR. WOODINGTON: I again would call the panel's
20 attention to the HPS chart which is part of the
21 record..

22 MS. BALLARD: Exhibit number?

23 MR. WOODINGTON: You get me every time.

24 COURT REPORTER: HPS is Six.

25 MS. BALLARD: Thank you.

1 MR. WOODINGTON: Number Six.

2 CHAIRMAN RAWLS: Number Six?

3 MR. WOODINGTON: Correct. And I just call the
4 panel's attention to the signature Anonymous
5 No. 1 over there in the right-hand column on
6 both of the pages, just to indicate that she
7 placed the sealant.

8 Q: Okay. Did Anonymous No. 1 ever contact you
9 about this patient to the best of your
10 knowledge?

11 A: I don't believe ... I don't believe about this
12 patient. I believe our only contact was about
13 ... I'm not going to swear to that. I know she
14 talked to me, she only talked to me one time.

15 Q: Okay. Are there any further developments on
16 the chart of this patient that would be of
17 relevance to this matter?

18 A: No.

19 Q: Okay.

20 A: We did see her again for a cleaning 9/04, and
21 that was the last time we've seen her.

22 Q: Okay.

23 MS. BALLARD: 9/2/04?

24 A: 9/2/04.

25 MS. BALLARD: Thank you.

1 Q: That's all I have, Dr. Chadwick. Thank you.
2 Answer any questions that Ms. Ballard might
3 have.

4 DR. CHADWICK - CROSS EXAMINATION BY MS. BALLARD:

5 Q: Dr. Chadwick, these patients were not patients
6 you had seen prior to them attending the school
7 program; is that correct?

8 A: That is correct.

9 Q: So as a result of seeing the dental hygienist
10 in the school, these two patients sought out
11 dentist care, correct?

12 A: I suppose. I don't know that for a fact, but
13 I suppose.

14 Q: If in fact the dental hygienist had sent
15 letters home with these students indicating
16 there's some problem with your child's teeth
17 and he or she needs to see a dentist, that
18 would have been the appropriate thing for the
19 hygienist to do, would it not?

20 A: Yes.

21 Q: Okay. What evidence do you have that sealants
22 are harmful to teeth?

23 A: I don't have any evidence. We do them
24 ourselves.

25 Q: All right. So what is your quarrel with the

1 sealant having been placed over either
2 incipient or gross caries?

3 A: Placing a sealant on those caries is not going
4 to do anything good for the tooth. Gross
5 caries is soft and it does not hold the sealant
6 well, which is probably why these patients had
7 partial sealants because the sealants had
8 fallen out. Sealants are really meant in my
9 eyes to prevent caries, and according to some
10 of the literature that Anonymous No. 1 sent me,
11 apparently in some cases of early caries it can
12 arrest decay. But in gross caries it's a whole
13 different story.

14 Q: Are you familiar with research that goes back
15 as early as 1972 from the Journal of Prosthetic
16 Dentistry that indicates that the presence of
17 sealants on incipient and more severe caries
18 actually inhibits the growth of the caries and
19 often arrests it completely?

20 A: What I was taught in school ...

21 Q: My question was, were you aware of the research
22 that goes back as early as 1972?

23 MR. WOODINGTON: Mr. Chairman, I'd ask that she allow
24 him to finish his answer.

25 MS. BALLARD: I want him to answer my question, not

1 his.

2 A: Okay. No, it's not in my practice to seal
3 decay.

4 Q: Okay. Now, tell me if you would, what harm
5 occurred to these patients as a result of
6 having sealants placed on their teeth?

7 A: None. None, in particular. The sealants were
8 just pointless.

9 Q: Pointless?

10 A: If you're going to refer the kid to a dentist
11 because they have cavities, why do you place
12 sealants first?

13 Q: Well, let me answer that for you. Isn't it
14 possible that, particularly in the rural health
15 setting, that a child who has never seen a
16 dentist before, who's on Medicaid, might not
17 make it to a dentist after all, correct?

18 A: Sure.

19 Q: So if we have caries on teeth and we don't know
20 whether or not that student is ever going to
21 make it to see a dentist, isn't it preferable
22 to arrest the growth of caries rather than
23 letting it continue unabated?

24 A: I think it's kind of a band-aid, it makes you
25 feel good, but it doesn't really do anything.

1 Q: It's not helpful to stop the growth of caries?

2 A: If it did, yes, that would be great.

3 Q: Are you aware of research?

4 A: But when you seal something up underneath like
5 that and it leaks because it's not sealed,
6 because it's gross caries then it's just going
7 to go nuts underneath the sealant because it is
8 sealed off and protected from the toothbrush.
9 You know, it's just not right to seal gross
10 caries.

11 Q: What evidence do you have that sealing gross
12 caries allows the caries to continue to grow?

13 A: There's literature on that side of the issue.
14 The literature that I believe in always taught
15 you don't seal gross caries. That's what I was
16 taught at school, is you only seal them ... you
17 seal teeth to try to prevent decay and, you
18 know, if you have an incipient lesion at the
19 time and you're not with a Diagnodent, you can
20 only use an explorer and you can't catch every
21 bit of decay with an explorer, nor can you see
22 every bit of decay on an x-ray.

23 Q: If the literature in fact suggests or in fact
24 establishes that the placement of sealies (sic)
25 on incipient or in some cases gross caries can

1 in fact cutoff the supply of oxygen and inhibit
2 the growth of bacteria in active caries, that
3 would be a good thing for a patient, would it
4 not?

5 A: Sure, it would be a good patient (sic), but I
6 don't buy it.

7 Q: What don't you buy?

8 A: You seal ... you try to seal something, a
9 sealant, okay, if you're trying seal gross
10 caries, you cannot.

11 Q: Because why? Why can't you seal gross caries?

12 A: It falls out because it doesn't adhere. Okay.
13 The dentin, or the enamel is soft. I'm
14 probably not putting this well. Dr. Sneed is
15 probably a better person to ask this question
16 to.

17 Q: If in fact ...

18 A: But ...

19 Q: Go ahead.

20 A: All right. If it worked as you say, it would
21 be absolutely great, but it's against
22 everything I was taught.

23 Q: What's the harm?

24 A: What's the harm?

25 Q: In a public health setting, if you've got a

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1 patient who has not seen a dentist and who may
2 never seen a dentist, what is the harm ...

3 MR. WOODINGTON: What ...

4 MS. BALLARD: Let me finish my question, Mr.
5 Woodington.

6 Q: What is the harm in sealing either incipient or
7 gross caries, what harm does the student
8 suffer?

9 CHAIRMAN RAWLS: Before you answer, Mr. Woodington?

10 MR. WOODINGTON: Mr. Chairman, I have two objections.
11 One is that Ms. Ballard should direct her
12 comments to the Chair and not to me; and number
13 two, the question has already been asked about
14 three times now and are getting repetitive.

15 CHAIRMAN RAWLS: I agree it's getting repetitive.

16 Q: Dr. Chadwick, what experience do you have in
17 the public health setting?

18 A: Public health, none.

19 Q: None whatsoever?

20 A: Well, I do volunteer work with the community
21 outreach and that's where we provide dentistry
22 for the indigent population.

23 Q: Did you file a complaint against Anonymous No.
24 1 ...

25 MR. WOODINGTON: Objection, Your Honor, Mr. Chairman.

1 Q: ... with the Dental Board?

2 MR. ROSEN: That's the same issue that we, I think
3 the panel's already ruled on.

4 MS. BALLARD: The panel did not rule, Mr. Chairman,
5 on issue of whether or not I could question
6 these witnesses about complaints. The panel
7 ruled on the issue of whether or not I would
8 receive copies of the complaints from the
9 Board.

10 MR. ROSEN: That was the ruling that the panel gave,
11 but we discussed the implications of that
12 ruling which would apply in this situation, and
13 it was the Chairman's decision, but it was
14 decided that this would not be proper testimony
15 as a result of that decision.

16 MS. BALLARD: Could I ask what the basis for
17 excluding the testimony would be?

18 MR. ROSEN: Well, they feel that the initial
19 complaint was confidential in every respect.

20 MS. BALLARD: What about the issue of bias? How am I
21 supposed to address the issue of bias if I'm
22 not able to examine this witness as to whether
23 he filed a complaint against my client?

24 MR. ROSEN: They have simply determined that the
25 initial complaint is not available and it is

1 not to be inquired into or he's not to answer.

2 CHAIRMAN RAWLS: He doesn't have to answer that
3 question.

4 Q: Dr. Chadwick, are you aware of who filed a
5 complaint against Anonymous No. 1?

6 MR. WOODINGTON: Objection again, Your Honor.
7 Anything testimony ... any question that she
8 asks that relates in any way to the contents of
9 the original complaint, whether it's the
10 identity of the complainant or the substance of
11 the allegations would appear to be covered by
12 the panel's ruling.

13 CHAIRMAN RAWLS: Objection is sustained.

14 Q: Dr. Chadwick, did you express concern to either
15 of these patients' parents regarding the
16 presence of sealants on these teeth?

17 A: I believe we just told the parents of these
18 caries and ...

19 Q: Did you ...

20 A: And they needed to be filled. We told them
21 they had cavities and they needed to be filled.

22 Q: Do you deny that you or anyone in your office
23 told the parents that the placement of sealants
24 over caries in these teeth actually was
25 damaging to these teeth?

1 A: I can only speak for myself, but I did not say
2 that to the parents.

3 Q: Are you aware of anyone in your office who ...

4 A: Not that I'm aware of.

5 Q: Let me finish my question, Mr. Chadwick. Are
6 you aware of anyone in your office who advised
7 the parents of either of these children that
8 the placement of sealies (sic) over ... excuse
9 me, sealants over incipital gross caries was in
10 fact harmful to the patient and it could in
11 fact make the tooth actually blow up?

12 A: I don't know about it, if anybody said that to
13 one of the patients, I'm not aware of it.

14 Q: Let me look with you, if you will, on your
15 Exhibit Number Two, Complainant's Exhibit
16 Number Two which is the, your record on M.A.
17 Do you have that one? All right. I'm correct,
18 am I not, that on 5/8/03 you took a Panorex and
19 bite wings on M.A.?

20 A: Uh-huh (affirmative response).

21 Q: Where are those?

22 MR. WOODINGTON: They're right here and I'll be happy
23 to introduce them. I didn't see them until
24 today.

25 MS. BALLARD: Can we introduce those into the record?

1 MR. WOODINGTON: That's fine with me, sure.

2 MS. BALLARD: I would like the record to reflect that
3 these were not produced to us ahead of time.

4 MR. WOODINGTON: I'm sorry?

5 MS. BALLARD: These were not produced to us ahead of
6 time. We've not seen them either.

7 MR. WOODINGTON: And neither have I until today.

8 MS. BALLARD: That's fine. What number?

9 COURT REPORTER: This will be Nine.

10 MR. WOODINGTON: Well, there are actually three
11 different photographs.

12 MS. BALLARD: Let's put them in an envelope and label
13 them like that.

14 MR. WOODINGTON: All right.

15 (Petitioner's Exhibit Number Nine was entered into
16 evidence.)

17 Q: Did you provide these x-rays on M.A. that's
18 been marked as Complainant's Exhibit Number
19 Nine ...

20 A: Right.

21 Q: Let me finish the question. To the Dental
22 Board? I'm not asking whether you filed a
23 complaint. I'm asking if you provided these to
24 the Dental Board?

25 A: Yes.

- 1 Q: When did you do that?
- 2 A: I brought these ... these in particular were
3 actually brought up here today.
- 4 Q: So the Dental Board had not previously had
5 access, as far as you know, to these x-rays
6 that are marked as Complainant's Exhibit Number
7 Nine; is that correct?
- 8 A: I don't believe so.
- 9 Q: Okay. Looking at Plaintiff's ... excuse me,
10 Complainant's Exhibit Number Two, on 5/8/03 you
11 filled a number of teeth, correct?
- 12 A: Yes, ma'am.
- 13 Q: Included among that is tooth number thirty; am
14 I correct?
- 15 A: I believe so.
- 16 Q: Well, look at the record, Exhibit Number Two.
- 17 A: Yes.
- 18 Q: Is that correct, Dr. Chadwick?
- 19 A: Yes, we filled number thirty.
- 20 Q: All right. And you filled it again about a
21 year later; am I correct?
- 22 A: That's correct.
- 23 Q: So what was the problem with the first one?
- 24 A: Recurrent caries.
- 25 Q: So the application of the filling did not

1 arrest the growth of caries?

2 A: No.

3 Q: In tooth number thirty?

4 A: In that particular tooth and in the buccal of
5 19.

6 Q: So if in fact the literature would suggest that
7 the placement of a sealant over that would have
8 arrested the growth of caries in that tooth,
9 would you agree with me that it would have been
10 better to leave the sealant in place?

11 A: No. No, not at all. The sealant would never
12 have arrested the decay. I did the ...

13 Q: I said if the literature would reflect ...

14 A: I did a filling and she got recurrent cavities.
15 A sealant sure as heck was going to have caries
16 underneath.

17 Q: My question was, if the literature will reflect
18 that the sealing of a tooth will arrest the
19 growth of caries, would you not agree with me
20 that placing ... that filling this tooth at
21 that point allowed the caries to continue to
22 grow whereas a sealant might have prohibited
23 the growth of caries? If that's what the
24 literature reflects?

25 A: Ma'am, the literature can't possibly tell me

1 that it's better to seal a tooth, to seal
2 caries, gross caries, than it is to fill a
3 gross carie. I don't see how that can happen.

4 Q: How in the world, if you don't know a child is
5 going to go to a dentist in the future, how in
6 the world is a hygienist in a school-based
7 public school program supposed to determine
8 whether to put sealant on a tooth if she has no
9 reason to know whether this child will ever see
10 a dentist before (sic)? How is she supposed to
11 decide that?

12 MR. WOODINGTON: Your Honor, I object to the
13 relevance of that. That's not relevant to the
14 issue of whether the sealants were properly
15 placed or not.

16 MS. BALLARD: With all due respect, that's the exact
17 question that is before this panel. This panel
18 is being asked whether these hygienists
19 deviated from the standard of care in placing
20 sealants on these teeth, and it is incredibly
21 relevant that these sealants were placed in
22 the context of a public school program in which
23 we had no knowledge, no hope, no reason to
24 believe that these children may ever see
25 dentists again. That is directly relevant.

1 MR. ROSEN: I just wanted to ask a follow-up
2 question. Is it going to be the Respondent's
3 position that the standard of care in these
4 situations is different from the standard of
5 care in general?

6 MS. BALLARD: No. The standard of care for a
7 hygienist working in a school setting though
8 has got to be compared as to the standard of
9 care working with other hygienists in the
10 school setting. The standard is different
11 perhaps, and that's for this Board to determine
12 and for the expert witnesses to suggest. But
13 if a dental hygienist has no reason to know
14 that this patient is ever going to see a
15 dentist and she has to make a determination
16 about whether to arrest the growth of caries by
17 applying sealants or not, that has got to be
18 relevant to the determination of the standard
19 of care.

20 MR. ROSEN: So then we are talking about two
21 different standards of care; one in the public
22 health setting and one in the ...

23 MS. BALLARD: I think there are probably multiple
24 standards of care. I'm talking about the
25 standard of care that Mr. Woodington is

1 alleging that my clients violated and whatever
2 this Board determines that might be.

3 CHAIRMAN RAWLS: We'll allow that question.

4 Q: Do you recall my question?

5 A: I'm sorry?

6 Q: Do you recall my question?

7 A: No, I'm afraid not.

8 MS. BALLARD: Can you read it back for us, please?

9 (Off the record discussion.)

10 Q: Dr. Chadwick, how is a dental hygienist in the
11 context of a public school setting supposed to
12 make the determination as to whether to place
13 a sealant on a tooth if she has no information
14 from which to determine that this ... let me
15 finish my question. If she has no information
16 from which to determine that this child will
17 ever see a dentist in the future again?

18 A: If it's hopeless, why do we bother?

19 Q: I'm asking you the question.

20 A: I don't know. You know, I just ... I feel like
21 it would have been a lot better in these cases
22 to tell the parents that they needed to be
23 filled, than to just seal them. I don't know.
24 I just feel that the parent has a false sense
25 of security. They look in the kid's mouth and

- 1 they see filling.
- 2 Q: Dr. Chadwick, how do you think these patients
3 showed up in your office?
- 4 A: Right. Because ... all right. Well, if you
5 want to treat the kids in the school system
6 differently than the kids in my office, it's
7 fine. You know, I ...
- 8 Q: This is my question. My question has nothing
9 to do with a child in your office. My question
10 has to do, how would a dental hygienist in a
11 school setting make a determination as to
12 whether to place a sealant on a tooth when she
13 has no idea whether or not a child will ever
14 see a dentist in the future?
- 15 A: In my eyes, it's against every bit they've been
16 taught.
- 17 Q: I'm sorry?
- 18 A: In my eyes, this is against every bit of their
19 training.
- 20 Q: So what should they do when they see caries on
21 a tooth?
- 22 A: When they see caries on a tooth, it should be
23 taken care of.
- 24 Q: How?
- 25 A: At least gross caries. Okay. If you want to

1 argue that perhaps you can arrest some decay,
2 but if you've got a cavity that cannot be
3 filled, cannot be sealed with a sealant, you
4 don't seal it.

5 Q: Are you opposed to the hygienist program in the
6 schools?

7 A: Absolutely not. I think, in fact, that it's
8 great.

9 Q: Why?

10 A: Because they need to have their teeth cleaned.

11 Q: What does it accomplish for us?

12 A: You know, some of these kids are never going to
13 see a dentist; I know that.

14 Q: So it's a good thing to have hygienists in the
15 schools, putting sealants ...

16 A: I believe ...

17 Q: Let me finish my question. Putting sealants on
18 teeth for children who may never see dentists
19 again, even if there are caries present?

20 A: I think properly placed sealants are a
21 wonderful opportunity.

22 Q: Regardless of the existence of incipient
23 caries?

24 A: Properly placed sealants. Okay ...

25 Q: You agree with me, correct?

1 A: ... sealants that are placed over sound tooth
2 structure.

3 Q: I don't have anything further.

4 DR. CHADWICK - RE-DIRECT EXAMINATION BY MR.
5 WOODINGTON:

6 Q: I have, I think, just one question, Dr.
7 Chadwick. And that is, did I understand your
8 testimony under cross-examination to be that if
9 the patient presents to a hygienist and has
10 gross caries, what did you think the hygienist
11 should do at that point?

12 A: Have the patient treated by a dentist.

13 Q: Okay. Refer the patient, in other words?

14 A: Right.

15 Q: As opposed to placing sealants?

16 A: As opposed to placing sealants.

17 Q: Okay. And just to make sure your answer was
18 clear, you're talking about kids that have
19 gross caries on their teeth?

20 A: Yes.

21 Q: Visible gross caries?

22 A: Right, gross caries.

23 Q: Okay.

24 MR. WOODINGTON: That's all I have, Mr. Chairman, the
25 panel obviously can ask questions.

1 MS. BALLARD: I have no further questions.

2 CHAIRMAN RAWLS: Okay. Does anybody on the panel
3 have any questions? (No response.) If not,
4 before our next witness, I'm going to call for
5 a short recess.

6 (Off the record, 12:22 p.m. to 12:38 p.m.)

7 KATHERINE A. WAY, R.D.H., being duly sworn testifies
8 as follows:

9 MS. WAY - DIRECT EXAMINATION BY MR. WOODINGTON:

10 Q: Ms. Way, would you state your name and address
11 for the record, please?

12 A: Katherine A. Way, 1818 Remount Road, Hanahan,
13 South Carolina.

14 Q: Okay. And what's your occupation?

15 A: Registered dental hygienist.

16 Q: And could you briefly state your educational
17 background?

18 A: I've got a degree in hygiene from the Medical
19 College of Georgia.

20 Q: Okay. How long have you been a practicing
21 dental hygienist?

22 A: Fourteen years.

23 Q: Okay. Has that all been in Charleston, the
24 Charleston area?

25 A: Yeah. Yes.

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1 Q: How long have you been working with Dr.
2 Chadwick?

3 A: I've been in this practice for ten and a half
4 years.

5 Q: Okay. In the same practice?

6 A: Yes.

7 Q: Now you were in here, I think, when Dr.
8 Chadwick testified about the two patients, T.M.
9 and M.A.?

10 A: Yes, sir.

11 Q: And did you ... you were the one who did the
12 initial examination of both of those patients,
13 according to the charts?

14 A: Yes, sir.

15 Q: Okay. Did you hear what he testified about the
16 presence of gross decay in certain teeth for
17 each of those patients?

18 A: Yes, sir.

19 Q: Without prolonging this, was there anything in
20 his testimony that was at odds with your
21 recollection of finding gross decay?

22 A: Say that again.

23 Q: Was there anything in his testimony that was at
24 odds with your recollection about the presence
25 of gross decay in those teeth?

1 A: No.

2 Q: Okay. So would it be your testimony ... strike
3 that.

4 MS. BALLARD: Object to leading.

5 MR. WOODINGTON: Strike that.

6 Q: Okay. The x-rays have since been introduced as
7 State's Exhibit Number Nine. Did you take
8 those x-rays yourself?

9 A: Yes, sir.

10 Q: Was there anything in those x-rays that caused
11 you to change your mind about the presence or
12 absence of decay in the teeth we've talked
13 about already?

14 A: Yes, sir.

15 Q: Caused you to change your mind?

16 A: No, sir.

17 Q: Okay. So in other words, what did the x-rays
18 tell you about the presence or absence of gross
19 decay in those teeth?

20 A: It confirmed the moderate to advanced stages of
21 dentinal caries.

22 Q: Dentinal caries?

23 A: Uh-huh (affirmative response).

24 Q: Okay. Now as a hygienist, what kind of
25 training do you receive with respect to the

1 need or the ability to recognize and look at
2 gross decay, or decay period, in teeth? What
3 kind of training did you get?
4 A: As far as diagnosing or seeing?
5 Q: Diagnosing.
6 A: We have several different ways that we look at
7 teeth before the doctor comes in for the
8 examination. We have explorers that we use
9 down in the pits and fissures of the posterior
10 teeth.
11 Q: Okay. Let me stop you there. For the lay
12 audience that may eventually read this, an
13 explorer is just like a little pick, right?
14 A: Yeah.
15 Q: Okay. Go ahead.
16 A: It's got a little ... it's a curved instrument
17 with a little sharp point that we take down
18 into the deep part of the fissure and the pit
19 to see if there's anything, any sticky part of
20 the enamel.
21 Q: Okay. So that's one way you diagnose decay.
22 What other ways are there?
23 A: We have a laser machine called a Diagnodent
24 that gives us readings as to how soft or how
25 hard the enamel is and we have guidelines that

1 are with the Diagnodent that recommend
2 numerically where you can go up to a sealant
3 and after that, restorative work will be needed
4 after that.

5 Q: How about do you recall if you used the
6 Diagnodent on any of these two patients, T.M.
7 and Ms. ...

8 A: I did around some of the areas that were not
9 sealed.

10 Q: Okay. Do you recall ... I don't think it's in
11 the record, is it, in the chart?

12 A: No, sir.

13 Q: Do you recall what you found?

14 A: High numbers.

15 Q: Okay. How about visible examination for the
16 presence of decay?

17 A: Very visible.

18 Q: Is that part of your training, to recognize
19 decay visibly?

20 A: Yes, sir.

21 Q: Okay. So we've done visibly. We've done
22 explorer, and we've done Diagnodent. Are those
23 all methods that you're trained to use in
24 recognizing or finding decay?

25 A: Yes, sir.

1 Q: Okay. Are there any others?

2 A: The radiographs.

3 Q: The x-rays?

4 A: Yes.

5 Q: Okay. Is a hygienist trained, as far as you're
6 aware, in the area of removing decayed material
7 from teeth?

8 A: No, sir.

9 Q: Do you do that as a hygienist?

10 A: No, sir.

11 Q: I think that's all the questions I have. Thank
12 you. She will have some probably.

13 MS. BALLARD: I have to ask the question about the
14 complaint in order for you to rule against me.
15 So I don't want you to think that I'm ignoring
16 your ruling.

17 MS. WAY - CROSS EXAMINATION BY MS. BALLARD:

18 Q: Ms. Way, did you file a complaint against
19 Anonymous No. 1 in this matter?

20 MR. WOODINGTON: For the record, I object. I don't
21 know ... we can probably handle this in the
22 future by stipulation or something.

23 MS. BALLARD: If we can stipulate that I would ask
24 that question of all the witnesses and he would
25 object and your ruling would be the same, we

1 can avoid it.

2 CHAIRMAN RAWLS: Okay. Ms. Way does not have to
3 answer that question. We can stipulate.

4 MS. BALLARD: Okay. For all future witnesses as
5 well?

6 CHAIRMAN RAWLS: Yes.

7 MS. BALLARD: Thank you.

8 Q: After you saw these patients, you had
9 conversations with Anonymous No. 1, did you
10 not?

11 A: Yes, she phoned me on two different occasions.

12 Q: Okay. You in fact had told the mother that
13 Anonymous No. 1 had caused damage to their
14 children by sealing teeth with caries present,
15 did you not?

16 A: No, ma'am.

17 Q: Did you not tell Anonymous No. 1 when you spoke
18 with her that your objection to this is that
19 you in fact yourself had a tooth sealed that
20 had caries in it?

21 A: Actually no, that's not what I told her. I had
22 a sealant placed on my tooth and another
23 hygienist, who no longer is employed with us,
24 who is very meticulous as I am, cleaned my
25 teeth one day and I had made it to the age of

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1 34 without any type of decay. And she noticed
2 that there was a dark area around the sealant
3 that was in my tooth, posterior tooth, and
4 asked that ... you know, we were pressed for
5 time because we get in the chair when we can
6 and asked if she could take a quick x-ray. She
7 didn't like the way the tooth looked. And
8 after the radiograph, x-ray excuse me, came
9 out, it was three millimeters from the nerve.
10 Q: And what did that tell you?
11 A: It told me that the sealant did not do the
12 proper job. It leaked.
13 Q: The sealant leaked?
14 A: It was strictly leakage of the sealant, yes,
15 ma'am.
16 Q: And is it your testimony that it would have
17 been discovered had the sealant not been in
18 place?
19 A: Yes, but the sealant is what actually caused
20 the decay.
21 Q: Tell me why that is, Ms. Way.
22 A: Tell you why that is?
23 Q: Yes.
24 A: Because my feeling, as far as not having any
25 other decay in any other tooth in my mouth,

1 that tooth still having a sealant in it ...
2 sealants typically do not stay in the teeth for
3 years and years. I only had a couple of teeth
4 left that had sealants placed in them when we
5 were in college and we were practicing on each
6 other. And that sealant that did not come out
7 on its own had been microscopically leaking and
8 it formed that dark haze around it which
9 alerted her to say, we need to take a
10 radiograph, I think that you've got some micro
11 leakage around your sealant because of the
12 darkness around the sealant.

13 Q: Have you not had that tooth x-rayed since
14 college?

15 A: Yes, ma'am.

16 Q: And had that carious activity not been seen on
17 previous x-rays?

18 A: No.

19 Q: Do you think it's possible that the existence
20 of that sealant slowed that growth down?

21 A: No, ma'am.

22 Q: You're firmly convinced ...

23 A: Ma'am, I ...

24 Q: Let me finish the question.

25 A: Okay.

1 Q: You are firmly convinced that the sealant on
2 that tooth caused the caries?

3 A: There is no doubt in my mind.

4 Q: And tell me what scientific evidence you have
5 to support that.

6 A: Because I had had an x-ray taken ...

7 Q: I want to know scientific evidence, Ms. Way.
8 What scientific evidence do you have?

9 MR. WOODINGTON: Mr. Chairman, she started her answer
10 and she's entitled to finish it.

11 MS. BALLARD: She started with a factual response,
12 Mr. Chairman. I asked her what scientific
13 evidence she had and I'd like a response.

14 A: I'm not a scientist that can give you that type
15 of an answer. I can ...

16 Q: Am I correct ...

17 A: I can give you radiographically that eight
18 months prior to that, there was no decay in
19 that tooth.

20 Q: So you have no scientific evidence, am I
21 correct, to support your conclusion?

22 MR. WOODINGTON: Objection. I think it's sort of
23 mischaracterizes the testimony here.

24 MS. BALLARD: Well, I asked ...

25 MR. WOODINGTON: X-rays are pretty scientific.

1 MS. BALLARD: Mr. Chairman ...

2 CHAIRMAN RAWLS: I think an x-ray is scientific

3 evidence.

4 MS. BALLARD: I asked her for scientific evidence and

5 she gave me none.

6 Q: So I now ask, do you have any ... it's true you

7 have no scientific evidence to support your

8 conclusion?

9 A: Nothing except ...

10 MR. WOODINGTON: Same objection, Mr. Chairman.

11 MS. BALLARD: Sustain it?

12 CHAIRMAN RAWLS: I don't think she has to answer

13 that.

14 MS. BALLARD: Okay.

15 Q: You testified a few minutes ago that when you

16 measured the bacteria in these teeth -- and I

17 may be using the terminology incorrectly ...

18 A: It's the density of the enamel.

19 Q: You said the numbers were high?

20 A: Yes.

21 Q: What's a high number?

22 A: Anything on the Diagnodent above a 27 or a 28

23 is considered early incipient decay and the

24 Diagnodent will register, the laser will

25 register all the way up to a 99, that's the

1 highest it will register, and I was getting
2 numbers up in the 60's and 70's and 80's.

3 Q: On both of these children?

4 A: Yes, ma'am.

5 Q: Okay. Now let me ask you this, since these
6 proceedings began have you conducted any
7 research into the use of sealants on incipient
8 lesions?

9 A: I get literature at the office all the time.

10 Q: From who?

11 A: Different hygiene magazines, dental literature,
12 all kinds of things come in the mail for me.

13 Q: Do you read them?

14 A: Yes I do, ma'am.

15 Q: Have you conducted any research since these
16 proceedings began to try to determine what the
17 history of sealants and the use of them on
18 incipient lesions is?

19 A: The literature that I have read has said that
20 sealants should be placed only on early
21 incipient decay.

22 Q: And what does it accomplish if it's placed on
23 early or incipient decay?

24 A: Basically the same thing I said with the
25 Diagnodent, very, very early, early decay.

1 Nothing that has extended anywhere close to the
2 enamel dentinal wall.

3 Q: My question was, what does it accomplish to
4 seal early or incipient carious lesions from
5 your research?

6 A: It's not my research. It's the research that
7 comes in the mail that I've read.

8 Q: From what you've read, what is the benefit of
9 sealing early or incipient carious lesions?

10 A: Hopefully to arrest the decay from going any
11 further.

12 Q: Sealants can do that?

13 A: If they're done at an early stage, very early
14 stage.

15 Q: And so you would agree with me from what you've
16 read that a sealant on an incipient or an early
17 lesion on a tooth that is properly applied will
18 cutoff the supply of oxygen to the lesion and
19 arrest the growth of bacteria, correct?

20 A: Correct, if it's a very small lesion.

21 Q: How do you define very small?

22 A: Well, we don't go by ... we use ... what I was
23 telling ...

24 Q: Mr. Woodington.

25 A: ... him earlier, that we use several different

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1 things before we decide whether a tooth is a
2 candidate for a sealant versus a filling.

3 Q: My question is, how do you define small?

4 A: I just told you. We use radiographs. We use
5 explorers.

6 Q: Those are tools.

7 A: We use Diagnodents.

8 Q: Those are tools, Ms. Way. How do you define
9 small?

10 A: That's how I define it. In dentistry there is
11 no ...

12 Q: That's how you diagnose it. How do you define
13 it?

14 A: How would I define it?

15 Q: Yes.

16 A: I would define it as a non ... you know, I
17 don't know what a definition of a sealable
18 versus restorative tooth would be in an actual
19 definition. I mean, we don't have ...

20 Q: Have you researched that?

21 A: We don't have definitions for this and this and
22 this. We use instruments and things that aid
23 us in diagnosing what can be done because each
24 tooth and each case is different. And so we
25 look at different methods to decide whether or

1 not a tooth should be filled or a tooth should
2 be sealed.

3 Q: Ms. Way, you testified that you used the
4 Diagnodent on teeth that did not have sealants.
5 Did you use it on the teeth that did have
6 sealants?

7 A: Those are the teeth that I used it on.

8 Q: The ones that did have sealants?

9 A: On the areas that were not sealed. You cannot
10 use a Diagnodent on top of a sealant. It will
11 give you a ... no reading at all.

12 Q: Do you have any experience with the hygienist
13 program in the public schools?

14 A: No, ma'am, I don't.

15 Q: Have you looked into it or tried to learn what
16 it is that the program is supposed to
17 accomplish?

18 A: I used to go into the schools myself when I was
19 younger and ...

20 Q: That wasn't my question, Ms. Way. Have you
21 researched or attempted to learn anything about
22 the program and what it's purposes are?

23 A: I know what the purposes are. The purposes are
24 great, to go in and see the children, educate
25 them, clean their teeth, and then hopefully

1 send letters home to every, each and every
2 parent of each child that they need to see a
3 dentist.

4 Q: If in fact the child has problems, the goal was
5 to get them to a dentist, is it not?

6 A: Yes, it is.

7 Q: And for both of these patients, that in fact
8 was accomplished, was it not?

9 A: I don't ... I couldn't say for certain that
10 they came to the office because of the ...

11 Q: These were new patients, were they not?

12 A: Yes, they were.

13 Q: Would you agree with me that if M.A. was seen
14 by Anonymous No. 1 on 4/7/03 and ended up in
15 your office on 5/8/03, that suggests that she
16 came to the dentist pretty soon after being
17 seen at the school, didn't she?

18 A: Yes.

19 Q: And you'd agree with me that T.M., if T.M. was
20 seen on 2/17/04 and 2/19/04, and she ended up
21 in your office on 3/4/04, she got to the
22 dentist pretty quick after seeing the
23 hygienist, did she not?

24 A: Yes.

25 MS. BALLARD: That's all I have.

1 MR. WOODINGTON: I just have a question or two, if I
2 may.

3 CHAIRMAN RAWLS: Sure.

4 MS. WAY - RE-DIRECT EXAMINATION BY MR. WOODINGTON:

5 Q: There was a little bit of a discussion a minute
6 ago about what constitutes a small amount of
7 decay and so forth. If the decay extends into
8 the dentin, is that in your opinion a small
9 amount of decay?

10 A: No, sir.

11 Q: Okay. Would you ever ... would you ever seal
12 a tooth where decay extended into the dentin?

13 A: Never.

14 Q: Okay. Thank you.

15 CHAIRMAN RAWLS: Okay. Can we dismiss Ms. Way?

16 MS. BALLARD: No objection.

17 CHAIRMAN RAWLS: Before we do it, any questions from
18 the panel? Are we going to have a long ...

19 MR. WOODINGTON: I expect Dr. Sneed will be awhile.

20 CHAIRMAN RAWLS: Counselors, you want to take a lunch
21 break before Dr. Sneed testifies?

22 MS. BALLARD: When should we be back?

23 CHAIRMAN RAWLS: It's five after one according to my
24 watch, so five after two. Will that give us
25 time around this area?

1 MR. WOODINGTON: I'm sure it is. There's numerous
2 places in the surrounding area.

3 MS. BALLARD: For planning purposes, could I just
4 inquire, are we planning to work late tonight?

5 CHAIRMAN RAWLS: Yes.

6 MS. BALLARD: Thank you.

7 CHAIRMAN RAWLS: Okay. We'll recess for one hour and
8 come back at five after two.

9 (Off the record, 12:59 p.m. to 2:09 p.m.)

10 CHAIRMAN RAWLS: Mr. Woodington, would you like to
11 continue with your case?

12 MR. WOODINGTON: Yes, Mr. Chairman. I would call Dr.
13 Sneed to the stand.

14 WILLIAM D. SNEED, D.M.D., being duly sworn, testifies
15 as follows:

16 DR. SNEED - DIRECT EXAMINATION BY MR. WOODINGTON:

17 Q: Dr. Sneed, would you state your full name for
18 the record, please?

19 A: William Daniel Sneed.

20 Q: Okay.

21 MR. WOODINGTON: Can you hear him, can the panel,
22 Chairman, can the panel hear him?

23 CHAIRMAN RAWLS: Yes.

24 Q: And what's your address?

25 A: 173 Ashley Avenue, Charleston, South Carolina,

1 29449.

2 Q: Are you here under subpoena?

3 A: Yes.

4 Q: What's your current position and how long have
5 you held it?

6 A: I'm the professor and chairman of the
7 Department of General Dentistry at the Medical
8 University of South Carolina. I've been
9 teaching since January of 1976. I've been
10 chair since about '80- ... about twenty years,
11 I guess.

12 Q: Okay.

13 A: In some department or another.

14 Q: Okay. I'm going to hand you a copy of your CV
15 so we can go over that a little bit.

16 MR. WOODINGTON: The panel members should have that
17 as our Exhibit One.

18 MS. BALLARD: It's been admitted without objection.

19 Q: Now, to just sort of do a little bit in the way
20 of highlights more than anything else and you
21 probably won't need to refer to this, but
22 first, what's your educational background?

23 A: I have a bachelor's from Erskine College and
24 DMD from MUSC, a master's degree from the
25 Citadel, and another master's degree from MUSC.

1 Q: What are the masters' degrees in?

2 A: One's in teaching and one's in health services.

3 Q: Okay. And I believe you had some military
4 service as well?

5 A: Correct. Two years active duty in the Navy as
6 a dentist and eighteen years in the Army
7 Reserve as a dentist, retired after twenty
8 years in the Reserve.

9 Q: Okay. And retired as a Lieutenant Colonel, is
10 that right?

11 A: Right.

12 Q: Could you describe your faculty appointments
13 very briefly?

14 A: Well, yeah. I came in as an associate, and
15 then an assistant professor and associate
16 professor, and then a professor with tenure.
17 I've been chairman of the Operative Department
18 when it was a department and then when it was
19 combined with General Dentistry, I became the
20 chair of General Dentistry.

21 Q: I'm just going to ask this without any clue of
22 what the answer might be, but what's the ...
23 General Dentistry, are there other departments
24 in the College of Dentistry also?

25 A: Oh, yes.

1 Q: What are those?

2 A: Department of Prosthodontist, which is fixed
3 and removable, which would be crown and bridge
4 and dentures. And then there is a Department
5 of Pediatric Orthodontics, Department of Oral
6 Surgery, and the Department of Stomatology,
7 which is a catchall.

8 Q: Would general dentistry embrace things like
9 sealants and so forth?

10 A: Yes.

11 Q: And diagnosis of tooth decay?

12 A: Correct.

13 Q: And treatment of tooth decay?

14 A: Correct.

15 Q: And how would you define, for the record,
16 operative dentistry?

17 A: Operative dentistry is the treatment of
18 individual teeth, the disease of individual
19 teeth; i.e. decay, and cosmetic procedures as
20 well. A lot of people just think of in terms
21 of fillings of single teeth.

22 Q: Let's go back a little bit... Have you been
23 practicing as a dentist while you've been on
24 the MUSC faculty?

25 A: Oh, yeah.

1 Q: How long have you been practicing?

2 A: About thirty years.

3 Q: Which is about the same time you were on the
4 faculty?

5 A: Correct.

6 Q: What kind of dental practice have you had?

7 A: General practice, focusing on fixed and
8 operative, restorative.

9 Q: Okay. Look at page four and if you can, just
10 highlight an editorial position or two or so,
11 that you've done in the past.

12 A: The Journal of Operative Dentistry which is a
13 journal from the Academy of Operative
14 Dentistry, I'm on the editorial board. I'm a
15 reviewer for dental materials, contributing
16 editor for, was contributing editor for Study
17 Club Magazine. For a few years there was
18 section editor for Quintessence, an editorial
19 board of Quintessence International.

20 Q: What's Quintessence?

21 A: It's a very respected journal in dentistry
22 published by the Quintessence Publishing
23 Company. I was fortunate enough to be asked to
24 be a section editor years ago. Manuscript
25 reviewer for the Academy of General Dentistry

1 and the Journal of Dental Dentistry, and
2 editorial board of the General Aesthetic
3 Dentistry. It's now called General Aesthetic
4 and Restorative Dentistry. And then did a few
5 years as an audio reviewer for Practical
6 Reviews in Cosmetic Dentistry, which is an
7 audio review service.

8 Q: Briefly, could you go over some of your work
9 and significant awards on pages four and five?

10 A: OKU is the honorary dental fraternity, I didn't
11 make it as a student. I was voted in as a
12 faculty member and I served as president and
13 president elect and all the offices. I'm very
14 proud of the lectureship awards that the
15 students have given me over the years. I've
16 won that several times. The Department has won
17 awards.

18 Q: How about the Pierre Fauchard?

19 A: Pierre Fauchard Academy is an honorary dental
20 society and last year they cited me with a
21 plaque for contributing to dentistry.

22 Q: Okay. Could you describe the subjects you've
23 taught while you were at MUSC?

24 A: Sure. Mostly in operative dentistry; advanced
25 operative dentistry; esthetic dentistry, that

1 would be amalgams, composites, ceramic crowns,
2 ceramic veneers, direct bonding, anything
3 basically to do with the single tooth,
4 sealants, excavation of decay, management of
5 the deep carious lesion.

6 Q: And you're teaching has included the use of
7 sealants?

8 A: Oh, yes.

9 Q: Okay. Has your teaching included instruction
10 about the standard of care in South Carolina,
11 which I was defined to mean, the degree of care
12 used by reasonably prudent dental healthcare
13 providers in South Carolina?

14 A: Well, at times we have referred to it as the
15 standard of care. We more refer to it as
16 evidence based dentistry as best we can
17 determine it. We try to teach materials and
18 techniques that are work proven, well proven.
19 I like to have five years of evidence and upon
20 that, we base what we teach and what's in our
21 curriculum. The standard of care evolves over
22 time and I think it's based upon evidence. We
23 happen to teach, we try to teach evidence-based
24 dentistry.

25 MR. WOODINGTON: Mr. Chairman, I could go on through

1 his resume some more, but at this point, I
2 would offer Dr. Sneed as an expert in dentistry
3 and in the diagnosis and treatment of tooth
4 decay and about the appropriate standard of
5 care in South Carolina as it applies to
6 dentistry and dental hygiene.

7 MS. BALLARD: All right. Could you give me those
8 again? Dentistry, the diagnose of ...

9 MR. WOODINGTON: Diagnosis and treatment of tooth
10 decay and an expert about the appropriate
11 standard of care in South Carolina with respect
12 to the practice of dentistry and dental
13 hygiene.

14 MS. BALLARD: We have no objection to him being
15 qualified as an expert in the field of
16 dentistry and the diagnosis of tooth decay. We
17 would not stipulate that he's an expert in the
18 field of the standard of care for dental
19 hygienists. There's been no testimony about
20 his background for that.

21 Q: What have you taught ... you taught dental
22 hygiene, dental hygienists in the past?

23 A: Years ago we had a bachelor program in dental
24 hygiene and I gave guest lectures in there, in
25 that curriculum.

1 Q: Are you familiar with the general
2 responsibilities of dental hygienists?

3 A: I believe I am.

4 Q: Are you familiar with what dental hygienists
5 need to know and should be aware of when they
6 practice?

7 A: I believe I am.

8 Q: Okay.

9 MR. WOODINGTON: I would again offer him on that same
10 point.

11 MS. BALLARD: It would be our position that the fact
12 that he is familiar with it does not qualify
13 him as an expert, and if he has some area of
14 expertise in the area of dental hygienists or
15 sealants, we would consider stipulating his
16 qualification as an expert in field of the
17 standard of care for dental hygienists, but we
18 don't think there's been sufficient showing
19 that he is ... being familiar with something is
20 certainly not evidence of being an expert.
21 I've gotten pretty familiar with the standard
22 myself.

23 CHAIRMAN RAWLS: We'll accept him as an expert
24 witness on the broad scale, including dental
25 hygiene practice.

1 Q: Let's now turn to the ... this is the Anonymous
2 No. 1 case, and let's now turn to the
3 individual details of the first patient we
4 discussed this morning. And you of course were
5 here when Dr. Chadwick and Ms. Wade testified?
6 A: I was.
7 Q: I'm going to hand you some parts, four
8 different photographs from State's Exhibit Two,
9 which are the color photographs taken by Dr.
10 Chadwick's office, and ask you to identify the
11 teeth that are shown on there, on that little
12 thing down on bottom lefthand corner.
13 MS. BALLARD: I just want to make sure I'm clear. I
14 have that Number Two was the, Dr. Chadwick's
15 ...
16 MR. WOODINGTON: You're right.
17 MS. BALLARD: ... treatment chart.
18 MR. WOODINGTON: You're right, Three.
19 MS. BALLARD: Eight.
20 MR. WOODINGTON: No. Is it Eight?
21 MS. BALLARD: Oh, Three. That's right. For M.A.
22 Exhibit Number Three. Thank you.
23 Q: With that correction, it's part of Exhibit
24 Number Three. Would you identify the ones that
25 I've handed you and comment on the extent of

1 decay shown?

2 A: I'm looking at tooth number 31 and I see a
3 sealant and a multitude of grooves. I see one
4 through which appears not to be sealed, the
5 remainder does appear to be sealed. Looking
6 through the partially optically opaque
7 sealants, you can see a halo of darkness
8 underneath the sealant, extensive halo, which
9 to me is indicative and diagnostic of a pretty
10 large amount of decay in that tooth.

11 Q: That's 31?

12 A: Yes.

13 Q: Okay. Take the next one if you will.

14 A: This is tooth number 19. I see a lower first
15 molar.

16 MS. BALLARD: Wait a minute. Wait a minute.
17 Nineteen?

18 A: Tooth number 19, which is lower left, first
19 molar.

20 MS. BALLARD: Okay.

21 A: I see a partially retained opaque sealant. In
22 the central pit there is what appears to be a
23 fairly obvious, what I would call decay,
24 cavitated decay, because of the optical opacity
25 to the surrounding marginal ridge and the

1 darkness again, particularly in the lingual,
2 the lingual groove, the lingual developmental
3 groove as it goes up the facial slope of the
4 lingual cusp. You can see pretty significant
5 haloing around that groove, which once again is
6 diagnostically, to me, it indicates that is
7 what I would call frank decay.

8 Q: Well, let me interrupt you right there for a
9 minute. How would you define frank decay?

10 A: Frank decay is decay that has progressed
11 through the dentino-enamel junction and when it
12 reaches the dentino-enamel junction, that's
13 where it spreads. It tends to spread right at
14 the DEJ. That's the widest extent of the
15 spread, therefore, when you look through the
16 enamel, you're looking into ... you're looking
17 through the enamel, which is translucent, into
18 the underlying discolored dentin, which has
19 absorbed pigment and stain from its surrounding
20 environment as it demineralizes. So a frank or
21 an extensive decay would be one that has
22 reached the DEJ and has spread significantly,
23 indicated in those little passages that I've
24 described, and it is decidedly into the dentin.

25 Q: You said that for number 19. Would you say

1 that for number 31?

2 A: I would say it's not as extensive, but it would
3 be my estimation that that has reached the DEJ
4 and is beginning to progress, yes.

5 Q: On number 31?

6 A: Yes, in my estimation from a visual approach.

7 Q: And of course in these cases, is it true that
8 the sealant is covering ... that the sealant is
9 opaque?

10 A: The sealant is opaque. As it thins out, it
11 becomes obvious and more translucent.

12 Q: Okay.

13 A: So that dark area may very well be covered, at
14 least partially, by the sealant. It appears
15 that the lingual groove probably is not covered
16 by the sealant.

17 Q: And do you know why that's not covered by the
18 sealant?

19 A: I don't know. Just the fact that I'm guessing.
20 It doesn't look like anything is there. I
21 don't know why.

22 Q: Let's move on to the next tooth.

23 A: Well, I might say ... I might say why it might
24 not be there, we know that it's very difficult
25 to bond to any carious tooth structure. You

1 don't bond to it as well as you do to high
2 quality coronal enamel. High quality coronal
3 enamel, it's very intact. You can bond
4 tenaciously to it and you get an excellent
5 seal, but when you start dealing with cavitated
6 or any kind of demineralized tooth structure,
7 the seal is decidedly compromised, and that may
8 be what occurred possibly, I'm speculating;
9 that the etch may have been ... I imagine the
10 whole thing was etched, but the bond did not
11 adhere as well to that area, because it appears
12 to be carious and may not have adhered as well
13 and may have come loose. Tooth number 15, this
14 one is not as obvious to me. It appears that
15 there is a partially retained sealant. The
16 occlusal lingual groove ...

17 MS. BALLARD: I'm sorry, Dr. Sneed. Number 15?

18 A: Yes, ma'am.

19 MS. BALLARD: Thank you.

20 A: Number 15, tooth number 15. The occlusal
21 lingual groove has a partially retained
22 sealant, as does the central groove and the
23 facial groove. The central groove is well
24 sealed it appears. The facial component of
25 that has lost the sealant or wasn't there or

1 whatever. The occlusal lingual, the groove
2 that I see there that has no sealant in it, it
3 appears suspect. That one would be on the
4 fence as far as whether or not it should be
5 sealed. Now you look closely at the central
6 pit where that opaque sealant is, you'll also
7 see a dark darkness, not as obvious as the
8 other ones, but a dark halo ... not a halo. I
9 wouldn't call that a halo. It's more of a
10 darkness as you're seeing through the enamel,
11 which is suspicious. Not as clear as the
12 others, but of suspect.

13 Q: And again, you're looking without the benefit
14 well, you're looking with the handicap of
15 having opaque sealant?

16 A: Right. Or transillumination is another thing
17 that hasn't been mentioned. Transillumination,
18 even on molars, is quite helpful sometimes, a
19 light, shining light through the tooth, but we
20 don't have that either. In the next photograph
21 ... which by the way, has been shown to be
22 quite accurate.

23 Q: And we also have x-rays, which we'll get to in
24 a minute.

25 A: I'm looking at number 18. I see what appears

1 to be a well retained sealant, intact
2 completely. Yet again, you look at the central
3 pit which is where you would expect to see the
4 decay. By the way, location is also
5 diagnostic. You would almost never see decay
6 up on a cusp tip, even though we do see it;
7 it's called Class VI. You see ... pits and
8 fissure are what's called Class I, and so you
9 always look at pits and fissures, the central
10 pits being likely to be the deepest and most
11 susceptible, so that's the first place you
12 look. You look where it most commonly occurs
13 and that's certainly a dark, darkness
14 underneath that sealant. And a little bit of
15 darkness is fine. The pits and fissure
16 typically are stained, but when you see an area
17 that is dark like that as you look through the
18 translucent material in the tooth, it's suspect
19 is all I can tell you. I would be very
20 concerned if I saw that in the clinic.

21 Q: Okay. Let me show you part of State's Exhibit
22 Number Nine, which is ... I think the date on
23 the bottom of those is 5/8/03, is that right?

24 A: Correct.

25 Q: And this is a part of State's Exhibit Nine,

1 which is the x-ray by Dr. Chadwick's office,
2 the bitewings, I think.

3 A: And this is this tooth?

4 Q: That's all the same patient.

5 A: Oh, same patient. Okay. So do you want me to
6 tell you what I see?

7 Q: Tell the panel if that confirms anything that
8 you just testified to, or doesn't confirm, or
9 what have you.

10 A: Number 3 ... let me just tell you what I see
11 here.

12 Q: All right.

13 A: Tooth number 3, which is the upper right first
14 molar, has very significant decay. As a matter
15 of fact, if I was doing an operative
16 restoration on this tooth, I would be concerned
17 about having a carious pulp exposure. Decay
18 typically is at least twenty percent greater
19 than what you see on an x-ray, and what I see
20 here is the distal facial (inaudible) already
21 receding from the insult of the decay and I
22 would expect to see twenty percent greater
23 demineralization beyond this x-ray, so a pulp
24 exposure would be a very real possibility on
25 tooth number 3. Tooth number 2 also appears to

1 have decay advancing at the DEJ, not as
2 extensive as number 3. Number 18 has an
3 occlusal pit lesion which is advancing into the
4 dentin radiographically. When you see an
5 occlusal lesion radiographically, it's in there
6 pretty well. It's not an incipient lesion. If
7 you see it on a radiograph clearly as we do
8 here, those are no longer incipient lesions.
9 They are at the DEJ, they're expanding, and
10 they're progressing towards the nerve.

11 Q: Let me interrupt you for just a second. Is
12 what you just described the same as frank?

13 A: Frank.

14 Q: Or gross caries?

15 A: Yes. Nineteen is not as clear. That one, the
16 best I can see in this light, I would say yes,
17 that one is at the DEJ as well, but not as much
18 as 18. Number 31, I would say that is at the
19 DEJ and is expanding, not nearly as bad as
20 number 3, but it would be very ... something
21 you would want to check clinically and with
22 transillumination and any other aids to confirm
23 whether or not that has cavitated.

24 Q: Is transillumination a technique that's
25 available to hygienists?

1 A: Oh, yeah.

2 Q: Let me, just in case the panel would like to
3 look over your shoulder or take a look at these
4 as we move on. Okay. Let me ask you as a
5 matter of opinion, should a dental hygienist
6 practicing with a degree of care used by
7 reasonably prudent dental hygienists in South
8 Carolina be able to detect frank cavitation on
9 a molar?

10 MS. BALLARD: I would object to the question. The
11 basis for the question is inapplicable to the
12 facts of this case. It has not been limited to
13 the school setting or the public health
14 setting. He's asking him questions about the
15 standard for dental hygienists generally,
16 without limiting it to the facts of this
17 particular case.

18 MR. WOODINGTON: I' like to go ahead and rephrase it
19 if I may and I'll ask it again.

20 Q: Dr. Sneed, how many standards of care do you
21 think there are in South Carolina for the
22 practice of dental hygiene, in terms of placing
23 sealants?

24 A: I would hope there's one.

25 Q: And what is that standard of care with the

1 respect to placement of sealants over frank
2 cavitation?

3 A: I would ... it's my opinion that placing
4 sealants over frank or gross carious lesions is
5 not the standard of care.

6 Q: Does it make any difference to you whether it's
7 in a public health setting or in a private
8 office if this occurs?

9 A: Not to me.

10 Q: I think I just asked the question, but I'd like
11 to ask it again now. So in your opinion,
12 should a dental hygienist practicing with a
13 degree of care used by reasonably prudent
14 dental hygienists in South Carolina be able to
15 detect frank cavitation on a molar?

16 A: Yes.

17 Q: Okay. And what's the basis for that opinion?

18 A: Well, the curriculum as I understand it, and
19 the hygiene program as I am sure it is taught,
20 the recognition of decay, detection of decay.

21 Q: And you heard Ms. Wade's testimony in here
22 earlier?

23 A: Yes.

24 Q: Should a dental hygienist practicing
25 consistently with the degree of care used by

1 reasonably prudent dental hygienists in South
2 Carolina be able to determine whether
3 cavitation on a molar extends beyond the enamel
4 and into the dentin?

5 A: Gross frankly decayed lesions, yes. There are
6 areas until you get to that what I would call
7 gross, and certainly some of these are, they
8 should know that. Now there are questionable
9 ... there are ones ... everyone has to make a
10 judgement call as to when that occurs, but
11 there becomes a time when it's grossly
12 cavitated; yes, they should be able to
13 determine that.

14 Q: Okay. Could you describe some of the things
15 that the hygienists should be able to, should
16 notice or otherwise be able to test for to
17 determine when gross decay is present?

18 A: The same things somewhat that I've already
19 described, but the appearance of it, also the
20 presence ... with an explorer, and we've talked
21 about what an explorer is. That's a very sharp
22 little instrument. You've all had it used in
23 your mouth. The tip of that is around, a sharp
24 explorer is around sixty microns in diameter
25 and it is very sharp, and you can use that and

1 certainly dental hygienists use it, dentists
2 use it. We now try to use it very carefully so
3 we don't cavitate, we don't push the lesion
4 further into the tooth, but certainly it's wise
5 to use that lightly to get a feel for how non-
6 coalesced fissures, by that I mean fissures and
7 pits that are deep, whether there's any decay
8 there or not. You get a feel for whether those
9 are highly susceptible. And if that little
10 instrument ... you feel down into that pit and
11 you feel a tug back like you're touching
12 leather, then that is highly indicative of
13 decay. So that would be a tool that would be
14 at the disposal of a hygienist. A
15 transillumination as I mentioned, you can do it
16 with an operatory light and a mirror. You can
17 do it with high intensity lights that are
18 designed for that purpose. They even make a
19 very expensive one these days. I can't
20 remember the name of it, but anyway,
21 transillumination. Also the color. Typically,
22 highly progressing ... rapidly progressing
23 decay is light in color. Slower progressing
24 decay is dark. Decay on a larger surface,
25 particularly on a smooth surfaces ... the

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1 texture is important, whether it is matte-like
2 or whether it is shiny and highly reflective,
3 that's a determining factor; whether when you
4 wet it, the white spots we call them, the white
5 demineralization go away or they stay when you
6 dry them. There are a lot of things that have
7 been forever, but all of these diagnostic
8 parameters and measurements are, those are at
9 the disposal of a hygienist. Certainly even
10 the Diagnodent, which I don't imagine they use
11 it in the schools, but certainly it would be
12 permissible.

13 Q: How about ... you may have spoken about visible
14 breaks and the integrity of the enamel.

15 A: Oh, yeah. Well, that's what I was trying to
16 talk about with the non-coalesced fissures.
17 With a very deep, very deep pits and fissures,
18 if you take the little explorer and you feel an
19 obvious break in the enamel. And then the
20 haloing, it's diagnostic too.

21 Q: Okay. And for those teeth that we've looked at
22 here, I think the four that you have the color
23 pictures of, in your opinion, are those teeth
24 that the frank cavitation should have been
25 diagnosed by the hygienist?

1 A: The best I can determine by what I look at, I
2 would ... it would be my judgement that those
3 are frankly cavitated lesions.

4 Q: And again, frankly cavitated lesions ...

5 A: Gross.

6 Q: ... should have been determined ...

7 MS. BALLARD: I would object to the leading.

8 A: It is my opinion that a hygienist is well
9 trained and they're very knowledgeable and
10 skilled and they have these diagnostic tools,
11 and I believe most dentists and most hygienists
12 that are well trained would recognize these as
13 gross decay.

14 Q: These being those four teeth?

15 A: Yes, sir. Certainly three of them, and
16 probably four.

17 Q: Okay. All right. Let's move away from this
18 specific patient ... no, excuse me. Let me ask
19 you another question or two about the other
20 patient, Miss T.M. Again, you've heard the
21 other testimony about what the hygienist and
22 one doctor, Dr. Chadwick, saw with respect to
23 T.M. Let me show you this x-ray which is
24 State's Number Eight and ask you what you see
25 on tooth number 3 on there.

1 A: Very significant occlusal decay. Once again,
2 almost as bad as the other number 3 that we
3 looked at. That one needs operative
4 intervention in my opinion.

5 Q: Do you have an opinion about whether that would
6 have been visible before the sealants were
7 placed?

8 A: It should be. It should be. Now, there are
9 times when it's ... it's been referred to in
10 the literature as hidden decay.

11 Q: Right.

12 A: And you can't always determine this, but I
13 would expect this one to have the haloing and
14 the darkness underneath the enamel. It's
15 spread that much.

16 Q: Okay.

17 A: There are times when it goes through the little
18 tiny pit and it gets very large in there, and
19 without this you wouldn't ... it would be
20 difficult to tell.

21 Q: And just for the record, to keep it straight,
22 this is the State's Exhibit Eight, the T.M. x-
23 ray of 2/19/04; is that right?

24 A: Right.

25 MR. WOODINGTON: This one has already been around

1 once. I don't know if it should go around
2 again, but I'll hand it up to you just in case.

3 Q: Now moving away from specific patients and into
4 general principles a little bit. Have you done
5 an investigation and study about the, with
6 respect to the application of sealants in cases
7 where decay is present?

8 A: Yes. Over the years I have of course read the
9 literature in preparation for lectures. I have
10 consulted with peers, attended continuing
11 education courses, read the literature as I
12 said, extensively done literature reviews, and
13 attended the, a very valuable meeting for me.
14 Of course, the Academy of Operative Dentistry
15 is always a very valuable meeting, but the
16 Coalition of Operative Dental Educators, we
17 meet every year, once a year, and it's the
18 operative educators in the Southeast region;
19 from Georgia, Tennessee, North Carolina,
20 Florida, Puerto Rico. And we sit around and we
21 talk about operative. And one of the issues
22 not too long ago was pit and fissure sealants
23 and technique for applying them, and we
24 reviewed the literature. So I've studied it
25 over thirty years and I feel very well informed

1 on it.

2 Q: Okay. Let me ask you this. Is it consistent
3 with the degree of care used by reasonably
4 prudent dental hygienists in South Carolina, or
5 dentists for that matter, to place sealants
6 over some kinds of decay?

7 A: Yes.

8 Q: And what kind of decays are those?

9 A: Incipient, small.

10 Q: And how do you define incipient and small?

11 A: Those would be the very small localized areas
12 in pits and in noncoalesced fissures, not a
13 broad area, but a very defined area; in the
14 pits and in the fissures that are deep and
15 noncoalesced, and displaying no indication of
16 reaching the dentino-enamel junction. Once the
17 decay has reached the dentino-enamel junction,
18 it begins to get, I begin to get concerned, and
19 particularly when it's spread significantly
20 laterally, because it spreads laterally first
21 and then spreads more in a conical direction
22 towards the pulp. And when you begin to see
23 this large area of haloing, that is what I
24 would call a large one. Small ones are
25 confined to the pits, small pits and small

- 1 fissures, so that when you seal them you are
2 much more likely to attain a very good seal.
3 Because under the best of circumstances it's
4 difficult to get a good seal. That's why
5 keeping things dry is so important, using good
6 technique, cleaning the pits and fissures, and
7 extending the sealant beyond those small pits
8 and fissures. As the decay becomes broader in
9 area and the pits and fissures become involved
10 more widely, it's much more difficult to attain
11 that good quality enamel upon which you can
12 place a sealant and achieve a good sealant. I
13 know that's much more than you wanted to hear.
- 14 Q: No, that's fine. So what is the effect, if
15 somebody places sealants over incipient decay,
16 which you say is proper, what's the effect on
17 that? What's that do?
- 18 A: The literature will tell us that it becomes
19 dormant and is arrested as long as it remains
20 sealed.
- 21 Q: I hate to keep asking this verbose question but
22 it's a legal question and I think I have to ask
23 it this way. Is it consistent with the degree
24 of caries (sic) used by reasonably prudent
25 dental hygienists or dentists in South Carolina

1 to place sealants over all types of decay?

2 A: No.

3 Q: What kinds of decay should not have sealants
4 placed over it if the standard of care is to be
5 complied with?

6 A: Those lesions that are determined by the
7 judgement and diagnostic skills of a
8 practitioner to be, to have reached the
9 dentino-enamel junction and/or to be extended
10 in an area in a pit or fissure, in an occlusal
11 surface area, that would compromise the
12 integrity of the sealant for the long term;
13 thereby, the idea would be, in my mind, it
14 would not be appropriate to place a sealant on
15 frankly or obviously decayed teeth for the
16 primary reason that you would, I think you'd
17 give a false sense of security to the patient
18 and to the parent, and you would be ... it
19 would be very difficult to achieve a hermetic
20 seal, a very good seal. It's difficult in the
21 first place, and when you have that much decay
22 that you're trying to achieve a seal that is
23 compromised enamel and dentin ... well, I hope
24 you're not trying to seal dentin, but you're
25 sealing enamel, they're more difficult, because

1 you need to get beyond the lesion onto solid
2 enamel in order to assure that it doesn't leak.
3 And I teach the management of the deep carious
4 lesion and as ... the textbook that we use also
5 says that when you're excavating one of these
6 very, very large lesions, when you have
7 absolutely removed all of the decay peripheral,
8 you have from the margin, which is the external
9 part of your preparation, in toward the pulp,
10 when you have achieved solid peripheral tooth
11 structure. I like to say as much as possible,
12 but four millimeters or so of solid tooth, and
13 you're getting very near the pulp, the nerve,
14 and if you take one more little bit of decay
15 off of that nerve you're going to have an
16 exposure, it is permissible in my mind at that
17 point to treat that with antimicrobial and to
18 place a filling. But the whole concept there
19 is to treat with antimicrobials and to achieve
20 a seal, a durable seal. If, when you're
21 excavating that lesion, you're not able to get
22 that solid peripheral tooth structure upon
23 which you can place your sealant, you may not
24 have a sealant. And if it breaks, if that seal
25 breaks and you've left decay, it is rampant.

1. It becomes ... in a matter of months you could
2. have an exposure, a toothache, a root canal.
3. So my concern with sealing a frankly cavitated
4. lesion would be just that. You might get a
5. sealant right now possibly, you may very well,
6. but is it going to stay there. We see it all
7. the time, a portion comes loose, now it leaks;
8. the patient has a false sense of security, it's
9. an opaque sealant, mama sees something white on
10. there, everything looks fine, and it may
11. progress extremely rapidly. The same thing
12. happens with a cracked filling. If you have a
13. cracked amalgam and the amalgam is loose but it
14. won't fall out, that's the worst possible
15. scenario because now it's leaking, saliva,
16. bacteria, sugar, so forth are getting up under
17. there. It would be better if it fell out. If
18. the filling fell out then it would be self
19. cleanseable, remineralizable to the calcium
20. phosphates and the fluorides in the oral
21. environment. So that's my concern.

22. Q: Okay. You make me want to stop and run down to
23. the dentist and make sure I don't have a broken
24. filling.

25. A: Or a loose crown.

1 Q: You stated several different conclusions just
2 then. Did you find support for those in review
3 of the literature, for those conclusions?

4 A: I believe so.

5 Q: Okay. Did you also sort of conduct inquiries
6 of some of your peers?

7 A: Oh, yes.

8 Q: Recently, within the last year or so?

9 A: Well, at the code meeting we talk about this
10 kind of stuff all the time.

11 Q: Right.

12 A: And since I knew this this issue has been
13 going on for twenty years and I have discussed
14 this many times over the years, particularly
15 with my friends in the Southeast at the school.
16 And I know clearly what their feeling is.

17 Q: Could you name me a couple of names?

18 A: Sure. Dr. Ed Swift at the University of North
19 Carolina, he's the chairman of the Operative
20 Dentistry Department. Dr. Frank Caughman,
21 former chairman of the Department of Oral
22 Rehabilitation at the Medical College of
23 Georgia, he's now the associate dean of the
24 Clinical Affairs. Dr. Robert Kavorik at the
25 University of Kentucky. Dr. Tom Berry who is

1 presently at the University of Colorado,
2 formerly the chairman of Restorative Dentistry
3 at San Antonio, Texas. And I'm trying to think
4 of anybody else.

5 Q: Well, he'll answer for himself, but you've also
6 talked about, conversed or communicated with
7 Dr. Simonsen?

8 A: I certainly did, and I think highly of Dr.
9 Simonsen.

10 Q: And I won't ask you to characterize what he
11 said, but you've been in touch with him. You'd
12 looked at several things. How about the
13 economic effect of placing sealants over gross
14 decay?

15 A: Well, that's not my area of expertise, but ...

16 MS. BALLARD: I would object. If it's not his area
17 of expertise, he shouldn't be answering
18 questions about it, Mr. Chairman.

19 MR. WOODINGTON: I'll let it go.

20 CHAIRMAN RAWLS: We'll will sustain the objection.

21 Q: Have you ever seen or read anything or heard
22 anything in professional letters or
23 conversations or otherwise, that would indicate
24 that it's appropriate and within the standard
25 of care to place sealants over gross decay?

1 A: There are minimal references to it in the
2 literature. My opinion and my knowledge of the
3 literature, the vast majority of the literature
4 under the standard of care is not to place
5 sealants over rampant decay, and I have a
6 multitude of references. They're always ...
7 you can always find references to support any
8 position, but the majority of the things I have
9 state that that is not the standard of care.

10 Q: Are you familiar with the concept of placing
11 sealants after sort of a light removal of
12 decay?

13 A: Yes.

14 Q: Do you have an opinion about the validity of
15 that?

16 A: That's a whole different, that's a whole
17 different animal. And I know Dr. Simonsen will
18 refer to Eva Mertz-Fairhurst, a classic
19 article, whereby they placed sealed
20 restorations over obviously decayed teeth and
21 over a ten year period the decay didn't
22 progress. If you read that article, however,
23 they did a type of preparation. As a matter of
24 fact, I've got the article and I'm sure Dr.
25 Simonsen has the article, and the photographs

1 are in there, where they entered into the
2 lesion with a burr. They also, this is
3 extremely important, they used a diamond to
4 extend the margin at least a millimeter beyond
5 the defective pit or fissure, which is what I
6 alluded to earlier. It's highly important to
7 get on solid tooth structure. That's what they
8 were doing. They were giving some, creating a
9 little bit of a box-like preparation into which
10 these restorations could go, but in addition,
11 they abraded the enamel with a diamond one
12 millimeter, at least one millimeter, beyond the
13 margin and then they used their adhesive. Now,
14 you get a much, much better bond to abraded
15 enamel, high quality abraded enamel. So a
16 diamond instrument or any instrument that takes
17 at least two hundred microns away from the
18 enamel, will remove the superficial fluoride
19 rich enamel. Fluoro hydroxyapatite, that's the
20 reason we use fluoride is to prevent acid
21 dissolution of the teeth. We use fluorides to
22 prevent cavities. Well, in this case when we
23 etch the enamel we want the acid to etch the
24 tooth. We want it to dissolve the tooth. So
25 we want to remove the superficial highly

1 fluoride rich surface, and that's what they did
2 with the diamond. My point being, they didn't
3 just place sealants, they placed sealant
4 restorations.

5 Q: Is that something that a hygienist could do in
6 South Carolina?

7 A: No, sir.

8 Q: One other question I think, and that is if the
9 hygienist does see an instance of gross decay
10 in a molar, or for that matter in any tooth,
11 what's the appropriate thing in your opinion
12 that the hygienist should do at that point?

13 A: My opinion, if diagnosed in their opinion that
14 it's a cavitated lesion, they would be wise to
15 advise the patient and the parent, certainly
16 the parent, that this tooth is highly
17 susceptible, highly likely to have a cavity and
18 they should seek restorative care from a
19 dentist.

20 Q: I said that was my last question. I have one
21 other one. In a case where you have frankly
22 cavitated lesions, does it nevertheless do more
23 harm ... what's the ... does it hurt anything
24 to place sealants over frank cavitation?

25 A: I think I tried to address that a little

1 earlier.

2 Q: I think you did too. I just wanted to make
3 sure I had the question.

4 A: Well, I think the main thing to me is that it
5 gives a false sense of security and you're
6 telling ... some of the children are bright
7 children. They know something's been done to
8 their tooth and they think it's been fixed,
9 maybe. And the parent knows something's been
10 done to the tooth and the parent may think
11 something's been done to take care of this
12 tooth, everything is fine, and it may be. But
13 if the sealant is placed on one that is frankly
14 cavitated and it breaks the seal, the seal is
15 optically opaque, it tends to hide what is
16 going on underneath there. So if the seal
17 breaks, the decay is going to resume and resume
18 very quickly because it cannot be self-cleansed
19 at all in my opinion. And so, now it's got
20 something white on it and it may be progressing
21 rapidly and in a hidden way, and it could be
22 quite dangerous because the patient's mother
23 wouldn't look in there and see a big black
24 hole, they'll see a white thing, until it's too
25 late. So I think there is potential, there is

1 potential for harm. If it's a hermetically
2 sealed thing, that's a whole other issue, but
3 to do that on frank decay is hard at best.

4 Q: Thank you very much, Dr. Sneed.

5 CHAIRMAN RAWLS: Cross examination?

6 DR. SNEED - CROSS EXAMINATION BY MS. BALLARD:

7 Q: Dr. Sneed, you said it was a potential for
8 harm, correct?

9 A: Correct.

10 Q: M.A. wasn't harmed by the placement of sealants
11 on her teeth, was she?

12 A: I'm not aware that she was. I'm not aware that
13 she wasn't. She ended up at the dentist.

14 Q: In fact, she ended up at the dentist a month
15 after she was seen by the hygienist ...

16 A: I ...

17 Q: Let me finish my question, Dr. Sneed. In fact,
18 she ended up at the dentist a month after she
19 was seen in the public school system, correct?

20 A: Correct.

21 Q: And that is in fact the goal of the public
22 school dentistry program is to get these
23 children to dentists if they need it, correct?

24 A: One of the goals as I understand it.

25 Q: All right. So you agree with me insofar as

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1 Anonymous No. 1 saw this patient, saw M.A. on
2 April 7th of 2003, sent a letter home
3 recommending that M.A. see a dentist, and she
4 did in fact see a dentist within a month, that
5 Anonymous No. 1 accomplished what the program
6 was intending to accomplish, did she not?

7 A: I think that was the correct thing she did,
8 right.

9 Q: And you'd agree with as to T.M., there was no
10 harm caused to T.M. ...

11 MS. BALLARD: Where are the pictures of T.M.? Just
12 an x-ray.

13 Q: You'd agree with me ... we don't have pictures
14 on T.M., I apologize. You'd agree with me that
15 there was no harm to T.M. as a result to having
16 -- let me finish my question -- as result of
17 having sealants placed on her teeth when she
18 was seen by the hygienist, correct?

19 A: To my knowledge there was none.

20 Q: And if in fact T.M. was seen by a hygienist in
21 the public school program on February 17th of
22 2004 and February 19th of 2004, and she ended up
23 in the dentist's office on March 4th, 2004, a
24 week later, that she benefitted from the public
25 school program, did she not?

1 A: If that's the reason she went to the dentist,
2 yes.

3 Q: Well, you're aware, are you not, that the
4 school-based program does in fact provide a
5 list of dentists and recommendations when the
6 case is appropriate for these children who may
7 never have seen dentists before to go to a
8 dentist, correct?

9 A: Correct.

10 Q: So you'd agree with me that M.A. and T.M.
11 benefitted from being seen by Anonymous No. 1,
12 correct?

13 A: As best as I understand it.

14 Q: Okay. Is public health dentistry a specialty?

15 A: For me?

16 Q: I didn't ask for you. I asked if it was a
17 specialty.

18 A: As far as I know it is.

19 Q: All right. And you have no expertise
20 whatsoever in the area of public health
21 dentistry ...

22 A: True.

23 Q: Let me finish the question.

24 A: Thought you were finished.

25 Q: You have no expertise whatsoever in the area of

1 public health dentistry, is that correct?

2 A: Correct.

3 Q: And you would agree with me that there are
4 others, other than yourself, who have far more
5 experience in that area than you do, correct?

6 A: Correct.

7 Q: You're opposed to the public school dental
8 hygienist program, are you not?

9 A: No, ma'am.

10 Q: Why not?

11 A: Twenty years ago, 1986, I was deputized by the
12 South Carolina State Board to go in and observe
13 the sealant program, which I did. I submitted
14 a report on what I determined. I think based
15 upon those studies back then and that
16 observation is why we have general supervision
17 today actually. So I think it's a very good
18 program. I have no problem with it whatsoever.
19 I think it's wonderful.

20 Q: And in fact these two students that we're here
21 about today benefitted from it, did they not?

22 A: I think probably they did.

23 Q: Do you know Dr. Simonsen?

24 A: I do.

25 Q: He's pretty much an expert in the field of

1 sealants, isn't he?

2 A: Yes, he is.

3 Q: You agree with me that he has significantly
4 more experience in the area of sealants than
5 you do, correct?

6 MR. WOODINGTON: I object, Mr. Chairman. I think
7 that's pitting the witnesses.

8 MS. BALLARD: I'm asking for his opinion. He's been
9 qualified as an expert. I'm asking for his
10 opinion.

11 CHAIRMAN RAWLS: We'll let Dr. Sneed answer.

12 Q: You'd agree with me Dr. Sneed that Dr. Simonsen
13 has far more experience in the are of dental
14 sealants than you do, correct?

15 A: He has far more credentials.

16 Q: You don't think he has more experience?

17 A: I doubt that he does. I think our experience
18 would be similar in dentistry and literature
19 reviews and teaching courses. His credentials,
20 I have no problem with his credentials. In
21 fact, they're wonderful credentials.

22 Q: Show me, if you would, on your resume, which
23 has been marked as Complainant's Exhibit Number
24 One, your qualifications in the area of
25 sealants.

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1 A: That's what I was describing earlier. We're
2 not talking credentials, we're talking about
3 experience.

4 Q: Show me your experience in sealants on this
5 resume.

6 A: I don't have the articles here. That's what I
7 would refer to as credentials.

8 Q: Point me in your resume -- let me finish my
9 question - - point me in your resume to one
10 single evidence of experience with sealants.

11 A: Experience is different from credentials.
12 There is not an experience level here nor are
13 there credential levels in this CV. But I
14 define experience and credentials as two
15 different things.

16 Q: And my question was, you'd agree with me, would
17 you not, that Dr. Simonsen has far more
18 experience with dental sealants than you?

19 A: Not far more. He has far more credentials than
20 I do, not far more experience.

21 Q: He's certainly published a lot ...

22 A: Absolutely.

23 Q: Let me finish my question.

24 A: No question about it.

25 Q: Well, I haven't finished it yet.

- 1 A: I'm sorry.
- 2 Q: He's clearly published in that area and you've
- 3 not at all, correct?
- 4 A: Correct.
- 5 Q: He's taught in that area and you have not,
- 6 correct?
- 7 A: Not correct.
- 8 Q: You've taught in the dental.... you've taught
- 9 dentists?
- 10 A: Absolutely.
- 11 Q: You've not taught dental hygienists?
- 12 A: I have given guest lectures in our
- 13 baccalaureate program many years ago.
- 14 Q: Guest lectures?
- 15 A: Correct.
- 16 Q: You've never been a professor in a dental
- 17 hygienist program?
- 18 A: Yes, I had an appointment in the Department of
- 19 Allied Health, which is where the hygiene
- 20 program was located.
- 21 Q: Let me ask you this. Would you agree with me
- 22 ... you would agree with me, would you not,
- 23 that M.A. and T.M. benefitted from being seen
- 24 by Anonymous No. 1 in this program, correct?
- 25 A: In the sense that they were referred to a

1 dentist, yes.

2 Q: And you would agree with me that no harm was
3 done to either of these ...

4 A: These ...

5 Q: Let me finish the question. That no harm was
6 done to either of these students as a result of
7 having sealants placed on their teeth?

8 A: That is my understanding.

9 Q: That's all I've got. Thank you.

10 MR. WOODINGTON: I have just a couple more, Mr.
11 Chairman.

12 DR. SNEED - RE-DIRECT EXAMINATION BY MR. WOODINGTON:

13 Q: Dr. Sneed, let me show you State's Exhibits Six
14 and Seven. This is this HPS chart for T.M.,
15 and see if you can tell the date when the
16 sealants were applied in that, please, if you
17 can.

18 MS. BALLARD: I would object unless ... this is a new
19 matter beyond the scope of what the cross
20 examination was. This is information that
21 should have been questioned, if at all, during
22 the direct examination.

23 MR. WOODINGTON: If I may be ...

24 MS. BALLARD: I did not ... may I finish? I did not
25 raise any issue related to this chart nor did

1 I even refer to this chart in my cross
2 examination. He's attempting to introduce new
3 information which he may not do on redirect.

4 MR. WOODINGTON: If I may be heard for a minute.

5 CHAIRMAN RAWLS: Sure.

6 MR. WOODINGTON: She's asked about what benefit or
7 detriment occurred to this patient. I just
8 want to show the chronology of what happened to
9 this patient so the doctor can answer the
10 question and provide an answer to the same
11 question.

12 MS. BALLARD: Again ...

13 MR. WOODINGTON: About harm, benefit or detriment to
14 this case.

15 MS. BALLARD: Anything related to what's on this
16 record is beyond the scope of what he testified
17 to on direct.

18 CHAIRMAN RAWLS: Your objection is not sustained. I
19 think the chronology that you brought out would
20 allow this line of questioning.

21 Q: Well, let me just ask you, Dr. Sneed, can you
22 tell when the teeth were sealed based on that
23 particular document? If you can't, we'll move
24 onto another one.

25 A: I'm not familiar with this document, so ...

1 what's NIC ... NIC and OHI I guess is oral
2 hygienist instruction. NIC, that's on 2/17,
3 slight ... I guess based upon this I can't
4 tell, no.

5 Q: Okay. Let me just ask it this way then, if I
6 may. If hypothetically a sealant stays on, is
7 applied to a gross carie and stays there for a
8 matter of weeks and then is removed and
9 restorative treatment is given to the tooth,
10 does that do the patient any good? The
11 application of the sealant?

12 A: No, other than the referral, but doing the
13 sealant didn't do anything to help the tooth.
14 The referral to the dentist did help.

15 Q: Could the referral have been made without the
16 placement of the sealant on the tooth?

17 A: Yes.

18 Q: Okay.

19 MS. BALLARD: I have nothing further.

20 CHAIRMAN RAWLS: Are you finished with Dr. Sneed?
21 Any Board questions, questions from the panel?

22 MR. WOODINGTON: With those exhibits and that
23 testimony on the Anonymous No. 1 case, the
24 State rests. We have concluded our case on
25 this particular item. As we discussed this

1 morning, the future cases will be shorter I
2 hope as the Court will adopt Dr. Sneed's
3 testimony by reference. I assume you don't
4 want to hear an argument from me at this point
5 and just continue on with the Respondent's
6 case?

7 CHAIRMAN RAWLS: Yes.

8 MS. BALLARD: We would have a motion at this point,
9 for a dismissal of the allegations and formal
10 Complaint in this matter on the basis that the
11 Complainant has failed to establish a standard
12 of care for the public school dentistry
13 program, and it may have failed to offer any
14 evidence that the standard of care in that
15 setting has been deviated from. The allegation
16 in the formal charges in this case indicate
17 that sealants were placed at school, that they
18 were placed over gross caries. There's no
19 allegation of harm. There's been no testimony
20 of harm. There's been no standard of proof
21 testified to for the school-based program. We
22 believe there's been a complete failure of
23 proof and we would ask that the charges be
24 dismissed at this point.

25 MR. WOODINGTON: Just briefly, Mr. Chairman. Dr.

1 Sneed testified that there's only one standard
2 of care for the practice of dental hygiene and
3 he testified that that standard had been not
4 complied with in this, with these particular
5 patients, so it's our position that the case
6 has been very well made out. And the question
7 of whether the patient has been harmed or not
8 does not pertain to the standard of care, it's
9 what the dentist or hygienist did, regardless
10 of whether any harm actually occurred the
11 patient or not. That's sort of beyond the
12 control of the professional. We would submit
13 that that motion should be denied and that the
14 case should proceed appropriately.

15 (Off the record discussion.)

16 CHAIRMAN RAWLS: We rule that your motion is denied.

17 So if you would like to proceed with your case.

18 MR. COLEMAN: Ms. Dunbar.

19 BEVERLY B. DUNBAR, being duly sworn, testifies as
20 follows:

21 MS. DUNBAR - DIRECT EXAMINATION BY MR. COLEMAN:

22 Q: Would you state your name for the record.

23 A: Beverly Brown Dunbar.

24 Q: Ms. Dunbar, where are you employed?

25 A: Midlands Technical College.

1 Q: And what are your duties there?

2 A: I'm senior coordinator in the dental hygiene
3 department.

4 Q: And if you would, tell us your educational
5 background.

6 A: I have a bachelor's degree in Dental Hygiene
7 from Loyola University in New Orleans. A
8 master's degree in Public Health Administration
9 from USC and I'm graduate certified in
10 Gerontology from USC.

11 Q: Okay. Let's just sort of cut to the chase. Is
12 there a difference between the general practice
13 of dentistry and the public aspect of going
14 into the schools? Is there a difference
15 between the two?

16 MR. WOODINGTON: I object because there's been no
17 qualification of her as an expert to testify.

18 MR. COLEMAN: Okay. I'll be glad to do that.

19 Q: How long have you been teaching at Midlands
20 Tech?

21 A: I started in '73, '74 and then I went to
22 Florence/Darlington and then Greenville Tech,
23 and came back in '77 to Midlands.

24 Q: And do you have any experience in the public
25 arena?

1 A: Yes.

2 Q: What is that?

3 A: Lexington District One schools, VA Hospital,
4 and they are no longer but the Head Start
5 programs across from Providence Hospital,
6 testimonies and working with Katherine Riley at
7 the half-way houses.

8 Q: And have you ever testified in court?

9 A: Yes.

10 Q: Have you ever been qualified as an expert?

11 A: Yes.

12 Q: In what courts? In this state?

13 A: Public Health Administration.

14 Q: Okay.

15 A: That comes ...

16 Q: Go ahead.

17 A: In '79 when I was doing my graduate work, I
18 worked under the director of Public Health at
19 DHEC and one project was going out to the
20 public health sites across the state and
21 interviewing the dentists that were in those
22 areas. And when I came back, the result was
23 that I was having private practice dentistry
24 practiced in a public health setting. Just as
25 you know with oral surgery, perio, or any of

1 the specialties, if you're a general
2 practitioner you have to put your name out
3 there that you have that expertise in perio,
4 and the level of knowledge for you to assess
5 those specialty areas is not what it is when
6 you're a general practitioner. Public is a
7 recognized specialty in dentistry.

8 Q: And do you consider yourself an expert in the
9 field of public health dentistry?

10 A: Public health.

11 Q: Public health.

12 A: Public health.

13 MR. COLEMAN: I would move at this time that she be
14 qualified as an expert in public health.

15 MR. WOODINGTON: Well, I don't object to her being
16 qualified as an expert in public health,
17 although I think the next question about two
18 different standards of care I'm going to object
19 on because I don't think she'll be qualified to
20 answer that question. If that makes any sense.

21 CHAIRMAN RAWLS: We'll accept her as an expert in
22 public health.

23 Q: Okay. And as part of your public health
24 duties, did you also focus in on the aspect of
25 preventative nature in the school, in the

1 public school settings, or the public settings
2 as a whole?.

3 A: Yes. I would like for them to submit the
4 article that was published in '95 from the
5 Association of Public Health Dentistry. And
6 I'd love for the panel to get copies of that
7 and read ...

8 MS. BALLARD: We'll get copies of that for them.

9 A: ... because ... well, I don't have it front of
10 me, but if you would, there's an area, it was
11 addressed earlier in regards to when you have
12 an individual, and again, in private practice
13 you're dealing with individuals. In public
14 health you're dealing with groups of people.
15 And how you assess and the determining factor
16 ... when we talk about standards of care,
17 you'll note in this publication when they
18 mention about you have your patient, you know
19 they're supposedly coming back to you,
20 continuous care, you make certain decisions.
21 And that is the standard of care you should
22 make in private practice. In this literature
23 that was published, it will tell you, when you
24 have a group of individuals that are not in
25 continuous care, you are much more -- I think

1 the word is "lavish" that's used in the text --
2 in determining when to seal. In Atlanta, over
3 at Henlin in '95 the public health
4 representative is stating when in doubt in a
5 public health setting, seal. And so when we
6 say standard of care, the standard of care in
7 public health is not the standard of care you'd
8 find in perio in a general office, of what
9 level they would want the plaque control to be,
10 when would you do perio surgery, does the
11 patient have to have a certain plaque control
12 score. The tools that you use are different,
13 and so again, going through with these public
14 health dentists who were trying to practice
15 private practice dentistry in public health, it
16 doesn't work. The theories are based
17 philosophically different. And this is the
18 frustration I, when I'm sitting here in front
19 of private practice seeing people. And the
20 concepts of public health are different and
21 they are a specialty. And your framework in
22 which you're working from is not the framework
23 that these individuals ... I would probably
24 suggest that the material they use to calibrate
25 these individuals, deciding what to do, was

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1 from the basic screen that was put out by Dr.
2 Lala who was a public health dentist, an MPH,
3 and he came from, it was developed from the
4 territorial STD's. And so again, we're talking
5 about two worlds of judgement, two world real
6 ... I mean, we're working in. And if you would
7 go to the material, you would understand that
8 the decisions they made with the standards of
9 care is what should have been, but you're not
10 working from that framework, you're working
11 from private practice settings.

12 Q: In the public arena, you said earlier if in
13 doubt seal.

14 A: That is what was said from a public health
15 representative from this association of
16 dentistry. And the research was done at the
17 National Institute in Bethesda, Maryland.

18 Q: And as an expert in the field of public health,
19 do you think that would be the standard in the
20 public health arena -- if there's a doubt, seal
21 them?

22 A: That is what was stated.

23 Q: And is that accepted within the public health
24 arena?

25 A: Yes.

1 Q: And is that what was done in this particular
2 case?

3 A: Yes.

4 Q: And are you familiar with the school-based
5 hygienist program?

6 A: Am I familiar with the program?

7 Q: Are you familiar with it?

8 A: Overall. I have, in the last semester with my
9 graduating seniors, they go on rotation out
10 into the schools with this company.

11 Q: And the purpose of it is to get these kids and
12 these children in the school setting in to see
13 a dentist?

14 A: Correct.

15 Q: And these are the kids that normally are not
16 seen by a dentist, isn't that correct?

17 A: Probably seventy-five to eighty-five percent of
18 them have not been to see them. Can I give you
19 some background?

20 Q: Sure.

21 A: I can't remember the date. It was a public
22 hearing, it was when the CHIP's money was
23 coming down here in the state and there were
24 some public hearings, and we were there. And
25 all the state agencies were coming forth with

1 their problems; transportation, missed
2 appointments, when they do show up in the
3 waiting room they bring the whole family, and
4 it's all over. These were the things they were
5 talking about. The stigma of being with the
6 CHIP's program or any other programs, and after
7 that public hearing, Ms. Byrd and I were
8 talking and we talked about the problems and
9 the bottom line is, go to them.

10 MR. WOODINGTON: Mr. Chairman, I ...

11 A: You don't have to have ...

12 CHAIRMAN RAWLS: Excuse me.

13 MR. WOODINGTON: We're getting pretty far afield from
14 what gross caries were sealed, I would submit
15 here. But ask him to ask a question and get an
16 answer to a relevant point.

17 CHAIRMAN RAWLS: I agree.

18 MR. COLEMAN: Okay, sir.

19 Q: You are familiar with the school-based
20 hygienist program?

21 A: Correct.

22 Q: And as far as the public health sector, you
23 would consider that to be a very good thing,
24 would you not?

25 A: A blessing.

1 Q: Okay. I want to go a little bit into the
2 history of the legislation as to how this
3 matter, how this particular program was started
4 if you could. We talked briefly about this.

5 MR. WOODINGTON: I again object. I don't see how
6 this can be relevant to the issue before the
7 panel.

8 MR. COLEMAN: It is relevant, Your Honor, because I
9 think what she will testify to, I know she will
10 testify to it, is over time there's been a
11 flipflop in the policy of the state in what the
12 legislation says as far as whether or not there
13 should be supervision or should not be
14 supervision, and I think that is one issue that
15 needs to be addressed in this particular
16 hearing. And she can testify as to the
17 legislative history behind all of this.

18 CHAIRMAN RAWLS: All right. How is that relevant to
19 this particular case?

20 MR. COLEMAN: It goes into whether or not it's the
21 standing order with regard to the dentist being
22 able to oversee and that type thing. In the
23 standard of care.

24 CHAIRMAN RAWLS: We'll allow this.

25 MR. COLEMAN: Okay.

1 Q: Do you remember the question?

2 A: You want me to give ...

3 Q: A brief legislative ... I think it started, you
4 and I had talked about the Newberry Sealant
5 Project.

6 A: Okay. To give a little history, in '86, '87,
7 and in '93, the legislative audit had
8 recommended general supervision. And right
9 about the time in '86, '87 ... it was '86, the
10 General Assembly erected the Department of
11 Health and Environmental Control to develop a
12 policy on sealant application. And I think you
13 visited the Newberry Project. And so they
14 wanted to see how it would be if a hygienist
15 was in the public school systems doing the
16 sealants and without supervision of the
17 dentists. Okay. The conclusion of that study
18 was, the Newberry Sealant Study demonstrated
19 that sealants could be applied by public health
20 hygienists in school-based settings without the
21 direct supervision of a dentist. This method
22 of application represents a cost effective way,
23 and it went on and on. It said the positive
24 results of it should be incorporated into
25 existing programs. And this is when they

1 wanted to start the sealant programs. Well,
2 what happened is, they wrote up the law to say
3 that a hygienist could go out to do this and if
4 a dentist was available, if a dentist was
5 available, they could check them; but if they
6 weren't available, they didn't have to. That's
7 how the law is written. That was passed May 9th
8 of '88. Later on, they found out that having,
9 with some of these having the dentists in the
10 private schools, that wanted the forty-five
11 days to be in there, they weren't getting much
12 results either. So then in 2000 the General
13 Assembly said no more with the forty-five days.
14 You don't have to do that. And since that time
15 in January, this is when -- and I guess Ms.
16 Byrd will give the numbers, the thousands of
17 children they've seen without. But at that
18 point when it started, that's when the State
19 Board came in, in July of '01 and passed an
20 emergency regulation ...

21 MR. WOODINGTON: Mr. Chairman, this ...

22 A: ... which contradicted ...

23 MR. WOODINGTON: ... is being litigated in other
24 forums, in a bunch of different forums, and as
25 I said in my opening statement and is shown by

1 our proof and by the formal Complaint in this
2 case, all we're talking about is the standard
3 of care for sealing gross caries, not what the
4 legislature did in 1988 or 2000, 2003, or
5 yesterday for that matter.

6 MR. COLEMAN: I think all of this does dovetail into
7 the standard of care. To show the void, that
8 the State is flip-flopping, and I think even
9 the Dental Association has, because all of this
10 was done in conjunction with the Dental Board.
11 And that's the purpose of this testimony.

12 CHAIRMAN RAWLS: I think we've heard about enough of
13 it though at this point.

14 A: You know that whole history, don't you?

15 MR. ROSEN: We need to ... I understand the need to
16 establish the standard of care, but we need to
17 focus in on it on it I think a little more
18 directly.

19 MR. COLEMAN: Okay. At this time I would like to
20 proffer her testimony for the record.

21 CHAIRMAN RAWLS: Okay. Any objection?

22 MR. WOODINGTON: Well, within limits I won't object
23 yet anyway, understanding that this ... Mr.
24 Rosen I assume will assure the panel this isn't
25 actually part of the record, this a proffer of

1 testimony, it's not necessarily going to be
2 considered at this point. I still object to
3 the relevance of it, but it's another issue
4 altogether.

5 MR. ROSEN: I understand. Go ahead if you would,
6 please.

7 Q: I think you were in '03.

8 A: When the regulation came forth, emergency
9 regulation, and then we had to go in front of
10 an Administrative judge, then they said that
11 what was wanting to be put back in, that
12 there's a forty-five day examination.

13 Q: After the sealant was placed?

14 A: After the sealant was placed, not prior exam.

15 Q: Right.

16 A: That it would, the General Assembly said we
17 want that out, then the Board said they want
18 that in.

19 Q: Who was pushing all this? I mean, you have two
20 different factions pushing a certain
21 legislation, is that correct?

22 A: Correct.

23 Q: Who's on one side, who's on the other?

24 A: Well, I hate to generalize. There's people in
25 both ...

1 Q: Well, I know that. For the most part though.

2 A: Basically the organized dentistry and the State
3 Board, and then you had consumers, health
4 nurses, dental hygienists that were on the
5 other.

6 Q: What was the outcome in that tug of war, so to
7 speak, in '03?

8 A: They took it out because that's what the
9 General Assembly ...

10 Q: The forty-five days?

11 A: Forty-five days.

12 Q: So where did it lay when they took the forty-
13 five days out?

14 A: Okay. That is when ... well, the General
15 Assembly had it removed and so this is when the
16 company continued to work as far as to be out
17 in the schools. Then ...

18 Q: So where did it lie once the forty-five days
19 out? Was that an general order that was set
20 and then they practiced, the dental hygienists
21 did in the schools, is that correct?

22 A: Right. Well, correct me, if that came down
23 there was a time period they could not work.

24 MR. WOODINGTON: Mr. Chairman, now she's asking other
25 people to fill in her testimony.

1 A: I wasn't sure with that. That wasn't my area.
2 What has basically ...

3 Q: Hold on, Ms. Dunbar.

4 MR. COLEMAN: I conclude the proffer at this time. I
5 want to show you what's been marked as Exhibit,
6 I guess, Respondents, Exhibit Number One. And
7 it has been admitted, it was stipulated to.

8 MR. COLEMAN: I think this has been stipulated to.

9 MR. WOODINGTON: Right. Actually Mr. Chairman, I
10 stipulated and don't object to its admission,
11 but question whether it's very relevant to this
12 proceeding. It's something you can get off the
13 internet or anywhere else if you wanted to.

14 MR. COLEMAN: They've stipulated to the admissibility.
15 I think it is relevant. This is the ALJ order
16 whereby the hygienists were allowed to go into
17 the school-based setting. So I do think it's
18 relevant. It sort of outlines the history of
19 what were getting in.

20 Q: In your opinion as an expert in the field of
21 general health, do you feel that the dental
22 hygienist program in the schools is setting the
23 goals or meeting the goals that have been set
24 forth by the legislature of this state?

25 A: Yes. And they're very appreciative, writing

1 thank you's.

2 Q: Who was very appreciative?

3 A: The legislators that are working for their
4 constituents in their areas.

5 Q: How about the patients?

6 A: I'm talking about the school districts.

7 Q: Okay.

8 A: The school nurses especially.

9 Q: Okay.

10 MR. COLEMAN: That's all.

11 CHAIRMAN RAWLS: Thank you. Mr. Woodington?

12 MS. DUNBAR - CROSS EXAMINATION BY MR. WOODINGTON:

13 Q: Ms. Dunbar, did I understand you to say there
14 are two different standards of care for sealing
15 gross caries, one for public health and one for
16 private dentistry?

17 A: Yes. There are two different levels, and if
18 you can get that copy from the Journal, if you
19 can ... because the decisions that you have to
20 make in a private practice when you have a
21 patient that has continuous care, you make
22 certain decisions. And when you're in the
23 public health with a large group and these are
24 not patients with continuous care, then you are
25 ... it is known and is advocated in the public

1 health arena to be more, I think, what was the
2 word used in the thing, lavish about what's
3 acceptable. In other words, you're going to
4 accept something that is more incipient or
5 wider or bigger because that's better than
6 nothing if they don't go and it might do it.

7 Q: Have you seen anything that says it's within
8 the standard of care in public health settings
9 to seal gross caries?

10 A: I've never seen anything written like that, not
11 gross, when you use the word "gross".

12 Q: Any description on frankly cavitated lesions?
13 Anything that says it's okay to seal those in
14 a public health setting?

15 A: I've not seen that term.

16 Q: Do you know ... can you state in the positive,
17 what have you seen that it's all right to seal
18 in the public health setting that maybe
19 shouldn't be sealed in the private setting?

20 A: If I have something that I know in a private
21 setting ... well, there's a lot of determining
22 factors right there. If you've got someone
23 who's got rampant decay and you ask them and
24 they're drinking Mello Yellow, and you see an
25 area, you're going to go ahead and fill.

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1 Q: Not if you're a hygienist though, right?

2 A: No. But I'm just talking about the decision
3 making process.

4 Q: What if you're a hygienist and you see that,
5 what do you do then?

6 A: That's when I'm going to ... well, number one,
7 I'm going to start with dietary counseling
8 about the Mello Yellow. But you take a whole
9 different track. Now with the child out there,
10 the likelihood of me seeing them regularly and
11 being able to observe them and not knowing if
12 they're going, I might seal something that I
13 wouldn't seal, depending on the oral habits of
14 the child. See, you're trying to make a
15 general statement here of decision making, and
16 each patient is unique.

17 Q: No, I'm asking about a very specific statement.
18 Have you reviewed the charts and the pictures
19 in this particular case, the Anonymous No. 1
20 case?

21 A: I have not.

22 Q: So you don't have an opinion about whether what
23 she did was within the standard of care or not,
24 do you?

25 A: Not on that. I'm just going on the theory.

1 Q: And again, you have not seen anything that says
2 in any standard of care in any setting,
3 assuming there's more than one, that it's all
4 right to seal gross tooth decay?

5 A: If that's what that is. And ...

6 Q: Do you ...

7 A: And again ...

8 Q: Let me ask a question. You have no knowledge
9 about whether the tooth decay in these cases
10 was gross or not because you're not familiar
11 with it, right?

12 A: I just know that in private practice, what we
13 have seen in public health, we're more likely
14 to seal something they might not in private
15 because of, again, the factors that ...
16 variables that we have to deal with, with the
17 different sectors.

18 MR. WOODINGTON: I think that's all I have.

19 MR. COLEMAN: If I may.

20 CHAIRMAN RAWLS: Sure.

21 MS. DUNBAR - RE-DIRECT EXAMINATION BY MR. COLEMAN:

22 Q: When you're talking about the two standard of
23 cares, between -- let me ask the question --
24 between public and private, what you're
25 testifying to is the public should be different

1

2 MR. WOODINGTON: I'll object to the leading, Mr.
3 Chairman.

4 Q: Okay. The public is different than the
5 private, correct?

6 A: As far as the delivery of care ...

7 Q: Right.

8 A: ... and decision making.

9 Q: And what, just list the factors as to why. One
10 would be?

11 A: Continuous care and the unknown is a big one.
12 What happens also as far as the home care, a
13 lot of times the socioeconomic element comes
14 into play. The ones that are seeking the
15 private practice is much higher as far as
16 parental monitoring or the value system in
17 their behaviors. And in the public health
18 arena we might have, not always, but more junk
19 foods and the value of oral care or overall
20 care is not the same.

21 Q: It's less in the public as in the private?

22 A: Overall, because who's seeking private practice
23 care, overall, your middle income and upper in
24 most instances. I would say, you know, it's
25 probably close to fifty percent, I don't know

1 what the numbers are, of individuals that don't
2 seek care in this state.

3 Q: In the public arena, in the public healthcare
4 arena, is it widely accepted that there is two
5 standards of care between private and public?

6 A: In most instances.

7 Q: It is?

8 A: Uh-huh (affirmative response).

9 Q: Thank you.

10 CHAIRMAN RAWLS: Mr. Woodington?

11 MR. WOODINGTON: And now I have to ask another
12 question.

13 CHAIRMAN RAWLS: Sure.

14 MS. DUNBAR - RE-CROSS EXAMINATION BY MR. WOODINGTON:

15 Q: Do those two standards of care have anything to
16 do with the sealing of gross carious lesions?

17 A: Well, if you're talking about gross ...

18 Q: That's what I'm talking about.

19 A: You know, it's when you're ... labeled gross,
20 you know, what is gross?

21 Q: You heard Dr. Sneed testify, were you present?

22 A: Uh-huh (affirmative response).

23 Q: I'm saying is there one standard of care that
24 says it's all right to seal gross carious
25 lesions?

1 A: If I'm using the word "gross" like I use it,
2 not. Now, I think that I want you to direct
3 that question to the expert. I'm not an expert
4 on that. That is more Dr. Simonsen.

5 Q: So you don't know what the standard of care is
6 to the issues of this case basically is what
7 you're telling me?

8 MR. COLEMAN: Your Honor, I'll object. I think what
9 she's testified to ...

10 A: God, I can't believe it.

11 MR. COLEMAN: ... she does have an opinion. And she
12 has rendered an opinion in public health.
13 That's what she testified to, that they are two
14 distinguishing standard of cares between
15 private practice and public health, that's all
16 she's testified to. She has not testified to
17 the standard as it relates to the application
18 of the sealants.

19 A: And I would suggest that even with providers
20 right there, if you took ten patients and had
21 each one of them, they would have differences
22 of opinion. If they did screenings and went
23 through and did the ... you would, if you could
24 double blind and they wouldn't know, the
25 readings would not be the same, how to treat

1 and what to do. That's a subjective thing.

2 Q: Would that include gross though, gross caries?

3 A: Define ...

4 MR. COLEMAN: Asked and answered. I think he should

5 ...

6 MR. WOODINGTON: I had a volunteer answer here. I'm

7 trying to get her to clarify it.

8 CHAIRMAN RAWLS: Yeah.

9 MR. COLEMAN: I think it's been asked and answered.

10 She wants a definition for gross.

11 MR. WOODINGTON: I'll withdraw it, Your Honor.

12 CHAIRMAN RAWLS: Thank you, Mr. Woodington. Any

13 other questions? Are there any questions from
14 the panel members?

15 DR. JETT: Yes. You are, y'all help me, our public
16 health expert, didn't we deem that, is that
17 right?

18 A: Yes.

19 DR. JETT: Are the teeth on individuals in a public
20 health setting any different than teeth on
21 private patients?

22 A: No. But the environment in which they live
23 are.

24 DR. JETT: I don't know if I'm directing this at you.
25 I think I'm just making a general statement.

1 We've had an expert witness, Dr. Sneed, who has
2 stated that there is no benefit in sealing
3 frankly cavitated teeth. As a matter of fact,
4 he even stated that it can be harmful in the
5 sense of sealing frankly cavitated teeth.
6 That's what a grossly cavitated tooth is, I
7 mean, grossly decayed tooth is. That it can be
8 harmful because it can hide and/or give a false
9 sense of security. And my question is, why
10 then, if there is no difference between the
11 tooth of a private practice patient and a
12 public health patient, and what he said to be
13 the case, then why is it that were are sealing
14 frankly cavitated teeth? And that's the
15 question that's before me.

16 A: I haven't seen the data, the x-rays, the
17 pictures. That arena, as far as the cavitation
18 and all, I would turn over to Richard. My
19 thing with the public health is telling you
20 that the decisions on how to treat have many,
21 many variables, whether it is continuous care,
22 the socioeconomics of what they're eating and
23 what their value system of brushing, and
24 overall ... the variables are different with
25 private practice and public health and so the

1 decision on how to treat does change.

2 CHAIRMAN RAWLS: Ms. Dunbar, I've got one question.

3 Is there a specialty in dental hygiene called
4 public health dental hygiene and are there
5 training courses for specifically dental ...
6 public health dental hygiene?

7 A: Public health hygienists, not in the state of
8 South Carolina. There are public health
9 hygienists, yes. I think North Carolina has
10 numerous public health hygienists. Yeah, there
11 are public health hygienists.

12 CHAIRMAN RAWLS: Okay. Any other questions? (No
13 response.) Okay. You're dismissed, Ms. Dunbar.

14 MS. BALLARD: We call Dr. Simonsen. Do you want a
15 break first?

16 MR. WOODINGTON: Since he's going to be awhile, I
17 wonder if we might take a break.

18 CHAIRMAN RAWLS: Okay. Five minutes.

19 (Off the record, 3:33 p.m. to 3:44 p.m.)

20 RICHARD J. SIMONSEN, D.M.D., having been duly sworn,
21 deposes and testifies as follows:

22 DR. SIMONSEN - DIRECT EXAMINATION BY MS. BALLARD:

23 Q: Dr. Simonsen, would you identify yourself for
24 the members of the hearing panel, please?

25 A: My full name is ...

1 Q: We'll start there.

2 A: ... Richard John Simonsen.

3 Q: What is your profession, Dr. Simonsen?

4 A: I am a dentist.

5 Q: Where are you employed?

6 A: I'm employed at the A.T. Still University in
7 Arizona, which is the newest dental school in
8 this country, as the associate dean for
9 Preclinical Affairs and Research.

10 Q: We've introduced, as Exhibit Number Five, your
11 C.V. Is this an accurate representation of
12 your professional background?

13 A: Yes, it is.

14 Q: Would you outline for me your experience and
15 credentials in the field of dental sealants?

16 A: Well, soon after I graduated from dental school
17 in 1971, I returned actually to Norway and
18 practiced in a community health setting in a
19 school. And it was there that I became aware
20 of, I wasn't taught this at dental school, I
21 became aware of sealants and what they were and
22 I developed a strong interest in them. When I
23 returned to this country in 1973, I was
24 teaching at the University of Minnesota and
25 there was a visiting professor there who was

1 probably the world's expert at the time on
2 dental bonding and sealants, Dr. Leon
3 Silverstone, and he became sort of a mentor for
4 me and it was ... so, in 1973, I really began
5 research projects and clinical use of sealants.
6 I had started them in Norway, but that was when
7 it really started.

8 Q: Have you conducted studies and written articles
9 in the field of dental sealants?

10 A: I have.

11 Q: Can you outline some of the articles and the
12 presentations that you've given? If you need
13 to, use your resume.

14 A: Well, I think I can remember. 1977, I believe,
15 was my first publication on sealants. I
16 published several over the years after that.
17 Then in 1991 was the final paper of my study,
18 which was a 15 year report which was published
19 in the Journal of the American Dental
20 Association. And since then, I've continued to
21 publish on the subject. And I think it was
22 2002, I had a review, a literature review of
23 sealants which really summarized everything
24 available in the literature. I looked up 800
25 articles, I referenced over 200 and I think

1 that was sort of a state of the art paper at
2 the time. And most recently, I had an article
3 published in Dental Clinics of North America.

4 Q: Have you served on any panels for the Centers
5 for Disease Control related to the sealants?

6 A: Yes, I have.

7 Q: What panel was that?

8 A: Well, right now I'm on their so-called expert
9 panel for school-based sealant programs.

10 Q: What is a school-based sealant program?

11 A: It's a program in a school that is designed to
12 introduce children to preventative dentistry
13 and to get them understanding, and their
14 parents understanding, that they need to
15 continue dental care throughout life and if
16 they have problems, visit the dentist.

17 MS. BALLARD: We would tender Dr. Simonsen as an
18 expert in the field of dentistry, particularly
19 with an expertise in the field of sealants and
20 cariology.

21 MR. WOODINGTON: We'll stipulate to it, accept that.

22 MS. BALLARD: Fine. Thank you.

23 Q: Dr. Simonsen, would you move over here so we
24 can show some slides ...

25 A: Yes.

1 Q: ... to the panel members, please?

2 A: Certainly.

3 Q: Dr. Simonsen, let me ask, if you would, to
4 briefly explain to the panel the history of
5 your research in the area of dental sealants
6 and their use in the public school settings.

7 A: Okay. I'd like to do that by using a few
8 slides.

9 Q: Let me move those chairs.

10 A: Okay. I reduced a presentation I gave to the
11 Centers for Disease Control in my role as a so-
12 called expert and the expert panel on school-
13 based dental sealant programs. And so I'd like
14 to take just maybe three or four minutes to go
15 through them. We've already gone through my
16 background. I was also editor-in-chief of the
17 journal that the expert witness described,
18 Quintessence International, for 13 years. And
19 I've had various academic appointments and I'm
20 presently the associate dean down in Arizona.
21 This is the population that we're talking
22 about, a population of children who don't
23 generally get any dental care. This happens to
24 be from the Phoenix school-based sealant
25 program. And it's these, underprivileged

1 mainly, children who have very little or no
2 access to health care that we need to help in
3 any way we can. The first article on sealants,
4 or really on the acid etch technique, which
5 paves the way for sealants and other
6 restorative procedures using bonding, was that
7 of Michael Buonocore in 1955. He published the
8 first study on sealants and, as we've gone
9 through, I have published, from 1977 up to the
10 present, a number of articles on pit and
11 fissure sealing. And this is what we're
12 talking about ... this is ... happens to be my
13 son. This picture is from almost ten years ago
14 and you can see 14-year retention on the first
15 permanent molars, eight-year retention on the
16 pre-molars and second molars, and this is
17 really what we're talking about. And if you'll
18 forgive me a little personal photo, this is my
19 son who I used for many years as a model for
20 tooth brushing and the importance of using
21 fluoridated toothpaste. And he actually became
22 a poster boy, if you like, for NIH, this was an
23 NIH poster on sealants and fluorides, and we'll
24 come back to where he is today. These are his
25 teeth, but this is what his teeth could look

1 like (indicating). This is gross caries and it
2 is a disease, we all know it's a disease,
3 multifactorial disease, and sometimes very
4 difficult to diagnose, particularly in pits and
5 fissures. I have three years of training in
6 cariology.

7 Q: What is cariology, Dr. Simonsen?

8 A: Cariology is the study of dental caries, the
9 study of the causes and the treatment of dental
10 caries.

11 Q: Go ahead.

12 A: And that was a graduate program, an NIH post-
13 doc fellowship at the University of Minnesota.
14 And it became very clear that not only is ...
15 are the multifactorial causes of dental caries
16 difficult to detect sometimes, but also it's
17 very difficult for an individual clinician to
18 diagnose caries. I'm sure if each one of us on
19 the panel and maybe even people in the
20 audience, were to say which areas of those
21 teeth are carious, we would come up with some
22 different answers, and that's understandable
23 and no one's wrong. It's just that it's a very
24 difficult disease to definitively detect and it
25 requires multiple bits of information. We've

1 heard tactile sense, we've heard visual sense.
2 These are some of the things that we look at in
3 determining whether a tooth is carious. So, is
4 that carious? I think some people might say
5 that's gross decay. Some people might say it's
6 incipient. Some people might question, well,
7 I don't know, which is probably the right
8 answer. Is this carious, is this carious; it's
9 very difficult to tell. In this particular
10 example, these teeth were air abraded and you
11 can see the first area that we looked at that
12 looked most vulnerable, in fact, has no caries
13 present. So, the correct decision would have
14 been to seal that tooth, whereas many
15 clinicians, I think, justifiably in their own
16 minds, doing what they think is best for their
17 patients, would have put a restoration in that
18 area. And neither one is wrong, whether we
19 seal it or restore it, because we can't define
20 the actual status of that tooth without
21 extracting it and sectioning it and examining
22 it histologically. Here, a higher powered view
23 (indicating). And I think we have to admit it,
24 that we are guessing when it comes to
25 diagnosing the carious status of pits and

1 fissures. We do our best based on our clinical
2 experience and the knowledge that we've learned
3 and the examination of a particular site at a
4 particular time, and come to a professional
5 judgement; but that's what it is, a judgement.
6 How would we judge this tooth, for example
7 (indicating)? I know that there are many
8 clinicians that would immediately restore that
9 tooth with, for example, a class one amalgam,
10 which takes out a lot of tooth structure and
11 puts the cusps at risk of cusp fracture, as we
12 see here. Others, perhaps, would have sealed
13 it. But what is the correct treatment for this
14 tooth when you get this one piece of
15 information (indicating)? This patient has had
16 that tooth in her mouth for over 60 years and
17 it is not diseased. Maybe there was caries at
18 one time. It might not be arrested. We don't
19 know. So, when you don't know the answer, I
20 think the best treatment is the most
21 conservative approach, whether it be to leave
22 it alone or keep observing it or to seal it,
23 whatever that option might be. This is gross
24 caries (indicating). This is my definition of
25 gross caries, when it is this large on the

1 occlusal surface. And obviously, no one is
2 talking about sealing something like this.
3 However, if there is a microscopic opening in
4 the fissure that caused that, then the
5 discussion becomes a different one. And one
6 can, I think with the best interest of the
7 patients at heart, have different opinions as
8 to what should be done with that tooth
9 depending on, as we've heard many times,
10 whether that patient is likely to return or not
11 to the dentist. So, should we apply sealant
12 here, here, or here? It's a judgement call and
13 I think ... it almost saddens me to be here and
14 to hear the arguments that I've heard here
15 today because I think everyone's trying to do
16 their best. Everyone's trying to do their best
17 for their patients; the hygienists are,
18 clinicians in private practice are, witnesses,
19 everyone's trying to do their best. And we're
20 really all part of one team and I don't think
21 anyone's done anything wrong. I've heard
22 stories ... I've heard in a lecture at the
23 Academy of Operative Dentistry that Dr. Sneed
24 mentioned, a very good meeting, one speaker
25 said all stained pits and fissures are carious.

1 That is an incorrect statement. That is an
2 incorrect statement as you saw from the 60 year
3 old's slide that was stained and there was no
4 caries present. So, the question here today
5 before us really is can I seal over a small
6 cariou lesion or should I remove the caries.
7 And everything that I've looked at today and
8 all the evidence that I see tells me that the
9 hygienists who are here before us today have
10 done what is right in their mind to do the best
11 for their patients. Since 1972, when Stanley
12 Handelman of Eastman Institute started this,
13 started this arm of research, we have seen
14 multiple studies that have come to the same
15 conclusion and that is that it is ... and why
16 these studies started was we didn't know what
17 would happen if we inadvertently sealed an
18 incipient lesion, because I'm sure I've done
19 that thousands of times. I generally seal
20 teeth that I diagnose as caries-free. However,
21 my diagnostic skills are no better than yours
22 and I'm probably wrong on many occasions and
23 I've sealed those teeth. And we have to know
24 what happens when this is done. And the only
25 way to know that is to seal visible, known,

1 diagnosed carious lesions. And that was ...

2 Q: And that's been done in studies?

3 A: That's been done in all these studies. It
4 started with Stanley Handelman. And here is an
5 example from Dr. Ron Jordan's study
6 (indicating). And you'll notice this goes way
7 back. This is not new information. This was
8 July 1976. Dr. Jordan sealed over that carious
9 lesion. Now, some might define that as gross
10 caries, some might define it as incipient
11 caries. I think it's more than incipient
12 because you can clearly see the size of it
13 there, but whatever our definition of it is, it
14 was clearly carious and clearly visible on x-
15 ray in July of 1976. Five years later, this is
16 the photograph that Dr. Jordan took
17 (indicating), you can still see the lesion
18 there despite the pattern on the wall, which
19 makes it a little difficult, but it's still
20 there. And five years later the x-ray is, you
21 have to take my word for it because it's not
22 dark enough to really see, but it's almost
23 identical to the x-ray that was taken five
24 years previously, the only difference being the
25 angle of the x-ray. So ...

1 MR. WOODINGTON: Excuse me, Dr. Simonsen, just a
2 minute. I don't mean to interrupt but in an
3 adjudicative setting it's a little bit hard to
4 object or otherwise address this when it just
5 goes on and on and lectures. If it's strictly
6 an academic or hypothetical lecture, it's ...

7 MS. BALLARD: He's describing what is shown in each
8 of these slides that he is showing to the
9 panel, and then we'll talk about that
10 afterwards.

11 MR. WOODINGTON: What I would ask is how much longer
12 he has to go on this because ...

13 A: A couple of minutes at most.

14 MR. WOODINGTON: I guess what I'd like to do is make
15 an objection known to the absence of a question
16 and answer format. This has gone on for about
17 ten or 15 minutes. I just want to make that
18 objection for the record. The panel can do
19 what it wants.

20 A: I'm just ...

21 CHAIRMAN RAWLS: I think we'll allow Dr. Simonsen ...

22 A: ... a couple more minutes. Thank you, Mr.
23 Chairman. Eva Mertz-Fairhurst, who was at the
24 Medical College of Georgia, and Dr. Sneed
25 already presented this, the conclusion to her

1 study was that bonded and sealed composite
2 restorations placed over the frank cavitated
3 lesions arrested the clinical progress of these
4 lesions. This was really a supplement to the
5 other studies that have been done on sealants
6 and to a much more extensive area of
7 restorations and came to the same conclusion.

8 Q: Can we go back to that for a minute?

9 A: We sure can.

10 Q: The language down here at the bottom of the
11 page, frank cavitated lesions, that's what
12 we've heard testimony about here today?

13 A: Correct, correct.

14 Q: All right. And the conclusion here is what?

15 A: Is that if ... basically what it says is if the
16 lesion is sealed off, a successful seal will
17 not allow the bacteria to remain in that lesion
18 to produce acid because they're cut off from
19 the source of nutrition and the lesion will
20 stop progressing. It will not necessarily
21 remineralize or heal itself, but it will stop
22 progressing.

23 Q: And that is a frank cavitated lesion?

24 A: Correct.

25 DR. COOMBS: May I ask a question?

1 A: Yes.

2 DR. COOMBS: In that language in there it says a
3 sealed composite restoration. Are you making
4 a differentiation between a sealant and a
5 composite restoration?

6 A: Oh, yes. Yes. This is ... this is taking the
7 sealant studies that were done, where sealant
8 was placed over caries, to the extreme and that
9 is cutting a hole in the tooth, making it a
10 restoration, leaving caries in the tooth, and
11 then sealing the periphery such that that
12 restoration is sealed off. So, it's a more
13 extreme form of what you would expect to see
14 from sealing over an incipient lesion. These
15 are from my 15 year study. I don't want to
16 spend ... I don't want to take up Mr.
17 Woodington's time, no more than a second on
18 this. But we sealed a group of patients and
19 had an unsealed control group and the ... this
20 is a matched pair (indicating). It was done in
21 a matched pair analysis, so this is a
22 randomized tooth from a randomized control. In
23 the controlled subject you can see five years
24 at the top and 15 years at the bottom. And
25 then you'll notice that not only did the

1 control, which did not get sealant, have
2 restorations but that at 15 years a cusp was
3 fractured. So, this is really the restoration
4 and re-restoration cycle that you get with
5 restorative dentistry, with routine restorative
6 dentistry, as opposed to trying to prevent the
7 restorations in the first place. So, this is
8 the sealant at 15 years. And my point with
9 this slide is had there been a small lesion, an
10 incipient lesion underneath that sealant, it
11 wouldn't have looked any different 15 years
12 later than it does right there. And I don't
13 know for sure that there wasn't, but my
14 diagnostic criteria at the time we did the
15 study was that that was a caries-free fissure.
16 But had it not been, it's my professional
17 judgement that there would not be any
18 difference, that that lesion would not have
19 progressed any more. There's also a study out
20 there that talks about sealants not doing any
21 harm, and the usual susceptibility to decay is
22 not altered by having them treated with a
23 sealant that is not retained. This is Herschel
24 Horowitz, Stan Heifetz, Dr. Paulson; three
25 outstanding researchers in the field of

1 sealants. I spoke to the American ...

2 Q: Can we go back to that one again? I'm sorry.
3 We heard testimony earlier that sealants cause
4 decay. Does the literature support that?

5 A: Absolutely not.

6 Q: And how do we know that?

7 A: Well, I've reviewed every single sealant paper
8 that there is and I have never seen a study
9 that has reported a single case of sealant
10 causing decay.

11 Q: Even if a sealant is placed ...

12 A: Even if it's placed and partially lost, it will
13 not create harm.

14 Q: All right, thank you. I didn't mean to
15 interrupt you.

16 A: In 1981, I had presented to the American Dental
17 Association on a forum that they had on pit and
18 fissure sealants, why their limited usage. And
19 part of that reason we're still talking about
20 today. It's why we're here. We're discussing
21 why are sealants used. And in this particular
22 example that we have before us, I think we have
23 hygienists now who are scared to place
24 sealants. And to me, that's a tragedy. It's
25 a tragedy of our profession. Sealants should

1 be much more widely used, they're clearly
2 beneficial in the literature and it's very
3 unfortunate that we have this disagreement that
4 we're having here today. So, back to my son,
5 and I just want to end up with a little
6 parental pride because now the kid who was a
7 sealant poster boy is now flying a 64 million
8 dollar machine in the U.S. Navy. And as an
9 immigrant myself, I couldn't be prouder. And
10 these are the kids that we're here talking
11 about and I just would really ... if I can just
12 make a plea that we all try to get together on
13 this, because I don't think there is anyone in
14 this room that doesn't want to do their very,
15 very best for this population. And I think we
16 have some minor disagreements that I hope we
17 can overcome. I thank you for the time to show
18 you that.

19 Q: Dr. Simonsen, what is the goal of a school-
20 based hygienist program?

21 A: I think it is to educate children and their
22 parents, to examine children, to prevent dental
23 disease, prevent caries, and to refer disease
24 that's already in progress that is beyond the
25 scope of treatment of the dental hygienist.

1 Q: In the context of a school-based dental
2 hygienist program, how is a hygienist supposed
3 to determine whether or not she should seal or
4 not seal?

5 A: Well, the difference between a hygienist in
6 public health practice versus a clinician in a
7 private practice is that in a public health
8 setting, you really have very little control
9 over whether you're going to see the patient
10 again or not. And I think that adds a
11 component to the hygienist's tasks and
12 responsibility, and that is to perhaps
13 sometimes have to assume that if you're seeing
14 a child for the first time at the dentist and
15 they are 12, 13, 14 years old, you have to
16 assume that the likelihood of them returning is
17 small. And the likelihood of them following
18 through on your advice or command, perhaps, to
19 go see your dentist, even if they've got the
20 names of dentists given to them, the likelihood
21 of that happening is small. And in that case,
22 they have to make some difficult and different
23 decisions than a dentist would in private
24 practice.

25 Q: In determining what the standard of care is for

1 a hygienist in a public school program, what
2 factors should be considered by the hygienist
3 in determining whether to seal a tooth?

4 A: Well, I think the normal factors, whether
5 there's caries present or not. Ideally, we
6 seal caries-free teeth. In the situation of an
7 incipient lesion and in the situation, perhaps,
8 where they judge that there is more caries than
9 just an incipient lesion, I think a judgement
10 has to be made as to what benefit ... we're
11 trying to reduce risk to a child, we're trying
12 to reduce the risk of dental disease. And
13 whether you delay the progress of disease or
14 you prevent disease, you're doing the right
15 thing.

16 Q: In determining whether to place a sealant on a
17 tooth that has some degree of caries, and we'll
18 come back to the degree of caries, in the
19 public school setting if you've got a student
20 eight to 14 years old who's never seen a
21 dentist before, how does that factor into your
22 determination of whether to seal a tooth that
23 has existing caries?

24 A: Well, if they've never seen a dentist before,
25 you would have to gage the responsiveness of

1 the parent who might be there, and the child,
2 to getting the care that's required to take
3 care of the disease. And if the judgement is
4 that the likelihood of them going to the
5 dentist is small, then I think the natural and
6 only decision is you seal the tooth.

7 Q: And that's even if the caries is more than
8 incipient?

9 A: It's not an ideal situation, this is not an
10 ideal answer. If I saw that patient in a
11 practice situation or at the University, I
12 would prefer to remove the caries.

13 Q: Correct.

14 A: I think that is the standard of care of ...
15 that's the Rolls-Royce treatment, if you like.
16 But if you're uncertain as to what is going to
17 happen, you're obligated, I believe, to do
18 whatever you can to slow the progress of the
19 disease. And so if you say, okay, this is a
20 child with caries, you tell the parent, you
21 tell the patient, you have a cavity here, I'm
22 going to put something on it that will help it
23 but it is not going to solve the problem.

24 Q: Let me give you a hypothetical. If you're a
25 hygienist working in a public school setting

1 and you examined and cleaned the teeth, done
2 fluoride treatment, for an eight to 14 year old
3 student who's never seen a dentist before and
4 there is some degree of caries present,
5 incipient or greater, when you don't have a
6 history from which to determine the likelihood
7 of this child returning to a dentist or going
8 to a dentist in the future, if you've got a
9 tooth with caries and you have two options,
10 seal or not seal, what does the standard of
11 care require the hygienist to do?

12 A: I believe it requires the hygienist to seal the
13 tooth.

14 Q: In fact, can you seal a tooth that has gross
15 caries?

16 A: Well, it depends on your definition of gross.
17 I showed a tooth with a gross caries where all
18 the enamel was gone because the tooth had been
19 repaired. And no, you could not seal that.
20 However, if that gross caries that was present
21 underneath the enamel was there at present
22 because of a very small opening in the central
23 fossa, you could seal that. So, theoretically,
24 you could seal it. And the talk we heard
25 earlier of not being able to seal caries is

1 based on sealing the inside of the carious
2 lesion, if you like, and it's correct, you
3 can't bond to soft decayed dentin, but you can
4 bond to the enamel that's above it. So, it's
5 perfectly easy to seal even large hidden
6 carious lesions, and I would argue that it is
7 in the best interest of the patient to do that
8 if ...

9 Q: In what setting?

10 A: If there is ... if you judge that it is
11 unlikely that that child will go for further
12 dental care. The only thing you lose is the
13 time you spent putting the sealant on the
14 tooth.

15 Q: If, in fact, you seal a tooth that has
16 incipient or even gross caries and the child
17 manages to go to a dentist based on the
18 referral or for some other reason sometime
19 after seeing the hygienist, what harm has been
20 caused to the student by the placement of the
21 sealant on that tooth if he later receives
22 restorative dentistry?

23 A: None whatsoever, providing they were informed
24 that they should go and see a dentist. If they
25 were not informed, then perhaps they would

1 develop a false sense of security that this
2 tooth is fine. What's going to happen to that
3 sealed tooth? The reason we don't recommend in
4 normal private practice to seal carious lesions
5 is that over time sealants wear down, and so
6 there will come a time when a carious lesion
7 that has been sealed could become active again
8 as the sealant wears down to a point where the
9 fissure connection with the oral fluids is once
10 again found. So, that is why in the ideal
11 situation, we don't do it. But in the
12 situation of trying to reduce risk to a child,
13 I think it's a good policy to seal caries where
14 the other alternative options of the child are
15 minimal.

16 Q: In your review of the literature and your own
17 studies, have you determined that there are
18 cultural differences between America and other
19 countries around the world in the likelihood or
20 the tendency to use sealants on ...

21 A: Oh, yes.

22 Q: ... decayed teeth? What has your finding been?

23 A: Well, sealants are much more widely used in
24 Europe, for example. Finland, which is a small
25 country, probably, I don't know the population,

1 I don't know, three to five million, I'm
2 guessing, 85 percent of 12 year olds have all
3 their teeth sealed. It's because it's a
4 controlled society, they have school-based
5 sealant programs and they can ... every child
6 gets to see the dentist twice a year. That was
7 the kind of program I was in, in Norway. In
8 this country, the use of sealants is far less.

9 Q: Why is that?

10 A: I think there's a variety of reasons. I think
11 you have to understand that there are some
12 clinicians that just don't believe in sealants.
13 And you know, much of what we do in dentistry
14 is what we believe. We don't have evidence
15 for everything we do. And a lot of it is based
16 on experience and belief and maybe ... maybe
17 they had a bad experience with sealants and
18 said, oh, that's not for me. There's a number
19 of reasons why that is. I think it's
20 unfortunate and I think it's ... it's sort of
21 a black mark on our profession in a way,
22 because the preventative technique could and
23 should be much more widely used. In Denmark,
24 for example, the standard of care in Denmark is
25 to apply sealants to teeth that have incipient

1 lesions, ironically. They don't ... they
2 regard putting sealant on healthy teeth as
3 over-treatment. The Scandinavians are ahead of
4 us in cariology and caries research and we are
5 gradually ... our caries treatments are
6 gradually following them. So, I find it
7 ironic, perhaps, that we're arguing over a
8 standard of care that some may not recognize
9 now but five years from now is going to be the
10 standard of care.

11 Q: Have you had an opportunity to look at the x-
12 rays and the photos we have of the one patient
13 that Anonymous No. 1 treated in this particular
14 case?

15 A: Yes.

16 Q: Did you have an opinion, based on your review
17 of those, whether the caries that were present
18 ...

19 MR. WOODINGTON: Excuse me, there were two patients.
20 Which one are you talking about?

21 MS. BALLARD: I said both of them but ...

22 MR. WOODINGTON: Oh, did you say both, I'm sorry, I
23 thought you said one.

24 MS. BALLARD: ... we have the photos on one. Yes.
25 No, both of them.

1 MR. WOODINGTON: Okay.

2 Q: From your review of the x-rays and on the one
3 patient, the photos that we have, what is your
4 belief as to the degree of caries that appeared
5 to have been present at the time these students
6 were presented to the dental hygienist?

7 A: Well, like I said, caries is a difficult
8 disease to diagnose and a lot of it is opinion
9 based and you need really more than one factor,
10 but there is definitely some shadowing. I
11 would say some fissures that looked suspicious
12 to me, if not carious. The pictures are not
13 very high quality so I think it's difficult to
14 come to a definitive conclusion based on those
15 photographs, but I would say that there was
16 some caries present.

17 Q: Based on your understanding of the purposes and
18 the goals of the public health school program,
19 do you have an opinion as to whether Anonymous
20 No. 1 deviated from the standard of care in
21 placing sealant on these two patients' teeth?

22 A: I think she did exactly the right thing, which
23 was to inform the patient they needed to get
24 treatment and to try to delay the progress of
25 the disease that was there by placing sealant

1 on the teeth. I perhaps would have covered all
2 the fissures. I think her decision, which was
3 perfectly appropriate, was to seal some areas
4 and leave some other areas that were not
5 apparently covered because they were, in her
6 mind, perhaps plainly carious, I don't know.
7 I might have sealed it all.

8 Q: Did M.A. and T.M. benefit from the treatment
9 they received at Anonymous No. 1's hands?

10 A: I don't think anyone can make that judgement,
11 but what I would say is that due to the
12 shortness of time between the sealing and the
13 visit to the dentist, I doubt there was much
14 benefit. Had the time gone six months to a
15 year, I think the benefit would have been more
16 apparent.

17 Q: If part of the goal of the public school
18 program was to get these students to dentists,
19 did we accomplish that?

20 A: Absolutely.

21 Q: Please answer any questions Mr. Woodington has.

22 DR. SIMONSEN - CROSS EXAMINATION BY MR. WOODINGTON:

23 Q: Good afternoon, Dr. Simonsen.

24 A: Good afternoon, Mr. Woodington.

25 Q: Obviously, you've been engaged in the study of

1 sealants for some decades now, I guess probably
2 close to 30 years, isn't that correct?

3 A: That's correct.

4 Q: Have you ever testified in a case, a
5 disciplinary case, before involving placement
6 of sealants or alleged standard of care
7 violations in the placement of sealants?

8 A: I testified in Kansas maybe 20 years ago on
9 some case where a dentist was alleged to, and
10 he was found to have, been placing sealants and
11 charging them as restorations. I think that's
12 the only time.

13 Q: But a lot of your professional reputation is
14 sort of tied up in the validity of the use of
15 sealants, I would take it, is it not?

16 A: That's for others to judge.

17 Q: And it's not your testimony that it's never a
18 mistake to place a sealant, I take it, or is
19 it? Would you testify that you can never go
20 wrong putting a sealant on a tooth?

21 A: No, you can place sealant on a patient who is
22 never going to develop caries, and if you
23 couldn't know that ahead of time, that would be
24 wrong.

25 Q: Well, that's ... of course, you never know that

1 ahead of time, do you?

2 A: Correct.

3 Q: But is there any other case where it might be
4 wrong to place sealants over caries ... on
5 teeth?

6 A: I really can't think of anything. Maybe you
7 could give me a hint as to what you're
8 thinking. I don't think so.

9 Q: So, it's your testimony that you just can't go
10 wrong placing sealants on teeth in any
11 situation?

12 A: Well, that's a very broad statement but given
13 the amount of time I've had to think about it,
14 I would have to say yes, that it is okay to
15 place sealant under any circumstance. You're
16 not going to do any harm.

17 Q: Of course, you heard Dr. Sneed testify here
18 awhile ago.

19 A: I did.

20 Q: Do you deny that if a sealant breaks loose or
21 partially loose that decay could accelerate
22 underneath the sealant?

23 A: That is incorrect according to the literature.

24 Q: And what literature would you cite in support
25 of that?

1 A: Well, the study that I showed there. The
2 Horowitz study in Kaliston, Montana showed
3 quite decisively that even a partially retained
4 sealant is better than no sealant at all.

5 Q: Are there any other studies besides that that
6 show that?

7 A: Yes, there are. I think I referenced them in
8 my paper.

9 Q: Okay. On the other hand, though, there aren't
10 that many cases where studies involve the
11 sealing of gross carious lesions, are there?

12 A: No.

13 Q: And why is that?

14 A: Because the indication, the original indication
15 for application of sealants is as a
16 preventative measure, not as a therapeutic
17 measure. The therapeutic measure came later.
18 But all the studies that I list at that one
19 slide showing a dozen or so of them, they were
20 placing sealant over carious lesions.

21 Q: Now, is that the Mertz-Fairhurst 1998 article?

22 A: No.

23 Q: Okay. Let me ask you about that article.

24 A: Sure.

25 MS. BALLARD: Can you give him a copy of it?

1 MR. WOODINGTON: I can after I read to him out of it.

2 MS. BALLARD: Okay. What exhibit number is that?

3 MR. WOODINGTON: It's not in evidence.

4 MS. BALLARD: Okay.

5 MR. WOODINGTON: I don't plan to introduce it.

6 Q: Do you recall, and I'll read this and I'll let
7 you look at it and see whether it refreshes
8 your memory, that in the case of some of the
9 sealants they did do a bevel in the enamel of
10 the frank cavitated lesion and they did remove
11 some opaque demineralized enamel with a burr
12 until they reached translucent sound enamel.
13 Does that sound correct to you about what they
14 did before they placed the sealants?

15 A: Yeah. Well, no, they didn't place sealants.

16 Q: In that case?

17 A: No, in that study.

18 Q: I thought your testimony was that in the 1998
19 Mertz-Fairhurst study that there was placement
20 of sealants ...

21 A: No, sir.

22 Q: ... over frank cavitation?

23 A: No, sir.

24 Q: Okay. What's the study that has that?

25 A: There's probably hundreds of them. The

1 Handelman study was the first one in 1972.

2 Q: On frank cavitation?

3 A: Yes. And the slides I showed were from Dr.
4 Jordan's study.

5 Q: You testified, this is repetitive a little bit,
6 you testified that it could be appropriate, I
7 think, to seal large, hidden carious lesions.
8 Tell me what you said about large, hidden
9 carious lesions.

10 A: I didn't use the word "appropriate".

11 Q: Okay. What did you say?

12 A: I said in the event that the clinical judgement
13 of that operator is that this child is
14 potentially unlikely to return for treatment in
15 a short period of time, that it is beneficial
16 to the patient to seal caries.

17 Q: Okay. That's hidden carious lesions, large ...

18 A: Well, if it's hidden, you don't know it's
19 there.

20 Q: Okay.

21 A: So, obviously ...

22 Q: Well, you made reference to hidden lesions. If
23 it's not hidden, how about if it's a grossly
24 obviously piece of decay on a tooth, is it all
25 right to seal in that situation?

1 A: Well, you know, there's been talk of gross
2 decay and if you see shadows, that's indicative
3 that there is possibly a large amount of decay
4 underneath. But if you've got an intact enamel
5 surface above it and you manage to seal off the
6 one small area that is the cause of that
7 caries, then you are delaying the progress of
8 that disease. There's an international
9 committee that is formed of international
10 experts on caries, worldwide, that has come to
11 that same decision; that it is appropriate to
12 seal caries even though you can see the shadow
13 of caries below it.

14 Q: And where is that international?

15 A: It's called the ICDAS II study and, you know,
16 that's international ... I've got some writing
17 on it from the Centers for Disease Control and
18 it says the International Caries Detection and
19 Assessment System and it says teeth, in both
20 ICDAS II Categories Three and Four, should be
21 sealed under school-based sealant programs.
22 And Category Four is a cavitated lesion with an
23 underlying shadow, great dentinal involvement
24 and possible breakage in the surface.

25 Q: And where is that the standard of care, if

1 anywhere?

2 A: Well, it's the standard of care that the expert
3 panel on school-based programs is going to come
4 up with.

5 Q: For?

6 A: For the CDC.

7 Q: For the CDC?

8 A: Centers for Disease Control. And ICDAS is an
9 international committee, so it is going to be
10 a worldwide standard of care.

11 Q: Do you think there's going to be one standard
12 of care worldwide about this issue?

13 A: I believe so.

14 Q: Okay. You said you examined the photographs,
15 and I think ... did you also examine the x-rays
16 of these particular patients in these two
17 cases?

18 A: Yes.

19 Q: Okay. And you did state, I think, that caries
20 appeared to have been present on some of those
21 teeth, some of the molars, is that correct?

22 A: Yes.

23 Q: Would you deny that any of the ... how should
24 I say this ... would you assert that there was
25 no frank cavitation on any of those teeth?

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- 1 A: Well, it's really not possible to say because
2 they were sealed ...
- 3 Q: Well, you had ...
- 4 A: ... and you can't tell what's underneath the
5 sealant.
- 6 Q: But you also had x-rays, did you not?
- 7 A: Correct, yes. And the x-rays did show that
8 there must have been some frank cavitation,
9 which you might not have been able to see
10 clinically in terms of ... by frank cavitation,
11 I'm thinking of an opening into the tooth.
- 12 Q: And you had testified about sealants being left
13 off by Anonymous No. 1, I think, but do you
14 know for a fact whether the sealants were left
15 off in certain places or they just simply fell
16 off, do you know one way or the other? The
17 reason ...
- 18 A: I don't ... I don't know.
- 19 Q: Would you agree that it's not advisable to
20 place sealants over frankly cavitated occlusal
21 lesions for anyone where the option for
22 alternative conservative restorative treatment
23 is available?
- 24 A: Yes, under most circumstances, but if that
25 person said to me, well, I'm leaving for Iraq

1 tomorrow, I'm in the Army, I would seal it
2 because they might not get care for another six
3 months or a year.

4 Q: And of course, these students were not leaving
5 for Iraq tomorrow, as you know.

6 A: Correct, but they'd never been to a dentist
7 before, either.

8 Q: Right. Do you think there's a potential for
9 limited harm placing sealants over caries if
10 there's inadequate placement of the sealant?

11 A: In any procedure we do in dentistry, if it's
12 done inadequately, there is potential for not
13 fulfilling it's full benefit.

14 Q: Well, if sealant is inadequately placed for one
15 reason or another, isn't it possible for the
16 carie to continue to progress at that point,
17 under the inadequately placed sealant?

18 A: Sure.

19 Q: And if that happens, wouldn't the patient, and
20 the patient's parents in this case, wind up
21 with a false sense of security?

22 A: No.

23 Q: Why not?

24 A: Because they would have been told there was a
25 lesion that was there and they should go visit

1 their dentist.

2 Q: Well, if they were told there was a lesion
3 there. If they were just sealed and sent home,
4 they wouldn't know, would they? They wouldn't
5 be told ...

6 A: Well.

7 Q: ... they wouldn't be told that there was a
8 sealant inadequately placed over the carie,
9 would they?

10 A: No, they wouldn't be told that. Could you
11 rephrase your question, I think I ...

12 Q: What I'm saying is if a sealant is inadequately
13 placed, either because of the technique or the
14 person placing it or because of the nature of
15 the surface on which it's placed, isn't it
16 possible that the patient or the parents of the
17 patient could wind up with a false sense of
18 security?

19 MS. BALLARD: I would object to this line of
20 questioning. There is no allegation in this
21 case at all, in any of these cases, that the
22 sealants were inadequately placed. The
23 allegations and the charges in this case are
24 that the sealants should not have been placed
25 at all. So then why you're questioning about

1 the efficacy of the seal or whether it was
2 adequately placed is totally inappropriate in
3 these cases.

4 CHAIRMAN RAWLS: I think it's a reasonable line of
5 questioning.

6 A: Okay. So, your question was if it's
7 inadequately placed, could there be any harm?

8 Q: Correct.

9 A: Is that your question?

10 Q: Well, specifically, could the patient or the
11 parents wind up with a false sense of security
12 if the sealant was inadequately placed?

13 A: Well, a false sense of security, I know you
14 want me to say yes, but I can't say yes because
15 I can't imagine that a sealant would be placed
16 over a carious lesion without the parent or the
17 child being informed that there is caries
18 present and that requires attention of the
19 dentist. And if it's inadequately placed or
20 adequately placed, no harm is going to come
21 from that placement.

22 Q: Do you remember having an e-mail exchange with
23 Dr. Sneed about a year and a half ago on this
24 subject?

25 A: I don't remember.

1 Q: Let me show you this and see if it refreshes
2 your memory. This is a series of questions and
3 answers that he posed to you; his questions and
4 your answers.

5 MS. BALLARD: Have you produced that to me?

6 MR. WOODINGTON: I'm using it for impeachment.

7 MS. BALLARD: Have you produced that to me?

8 MR. WOODINGTON: I have not.

9 A: Okay. What do you want me to ...

10 MS. BALLARD: May I have a copy of it?

11 MR. WOODINGTON: We can stop and I can make copies,
12 if you want.

13 MS. BALLARD: I'd like that, please.

14 MR. WOODINGTON: Should we take a break so I can make
15 a copy of this before we proceed?

16 CHAIRMAN RAWLS: How close is the copier?

17 MR. ROSEN: There's a copier right in the room next
18 door.

19 MS. BALLARD: I'll go make copies.

20 CHAIRMAN RAWLS: We'll just all sit here for a
21 minute.

22 (Off the record, 4:29 p.m. to 4:30 p.m.)

23 Q: Let me direct your attention to the second page
24 of this, and first ask you if you recognize it
25 as an exchange of e-mailed questions and

1 answers between you and Dr. Sneed?

2 A: I guess so because it's got my name at the top
3 and my e-mail address.

4 Q: Okay. And that was on May 7th of 2004, right?

5 A: That's correct.

6 Q: Okay. Look on the second page, question five.

7 A: Uh-huh (affirmative response).

8 Q: Dr. Sneed had asked you this question and I'll
9 read the question and ask you to read your
10 answer. "Are we doing any harm," Dr. Sneed
11 said, "by placing sealants on these teeth,"
12 which we can define if necessary, "or is it an
13 innocuous practice? Some would say if it's
14 sealed, the lesion stops and if the bond and
15 seal is defective, the sealant is lost so no
16 harm is done." And you said, "the potential,"
17 if you'll start there.

18 A: Let me just read the question again. "Are we
19 doing any harm by placing sealants on these"
20 ... could I just see what these teeth are?

21 Q: "These teeth," I think refers to question
22 three, "frankly cavitated occlusal lesions."

23 A: Okay. "Some would say if it is sealed, the
24 lesion stops and if the bond and seal is
25 defective, the sealant is lost so no harm is

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1 done."

2 Q: And your answer starts with "the potential."

3 A: "The potential for limited harm is there. If
4 let's say an opaque sealant is inadequately
5 placed over active caries, this would allow the
6 caries to continue to progress under the
7 sealant. This is assuming the worst-case
8 scenario where the sealant is poorly placed,
9 allowing for leakage of the sealant. A false
10 sense of security could be acquired by patient
11 and parent. The major issue to me would be a
12 waste of valuable resources if sealants are
13 placed on teeth, carious, where no benefit is
14 accrued. That's more of an issue than the
15 devil's advocate position I took in answering
16 this scenario."

17 Q: Okay. Do you disagree with any of that now,
18 from a year and a half ago?

19 A: Well, it was a totally different question than
20 the kind of questions you've been addressing me
21 in the public health setting. I don't know
22 that this was defined to be in a public health
23 setting.

24 Q: Well, your next question was "should there be
25 a different" ... or is the next question ...

1 "should there be a different standard for
2 schools and practices," and read your answer to
3 that, if you will. Or just tell me your
4 answer.

5 A: "Very interesting question. I think I need to
6 think about this one for awhile."

7 Q: And have you thought about that for awhile in
8 the subsequent year and a half?

9 A: It depends how you define "standard", but
10 clearly to me, I would treat a patient
11 differently in a public health setting than I
12 would in a private practice, and that's not to
13 say that the standard of care is less or is
14 inferior in one over the other. It's just that
15 with the different circumstances that you have
16 in the public health setting, you have to take
17 into account many different factors that would
18 not be applicable in the private practice
19 setting. So, yes, there is a different
20 standard of care in those two settings.

21 Q: And for our purposes today, since what we're
22 talking about is the placement of sealants over
23 what some people have testified is frankly
24 cavitated decay, your answer would be that
25 there are two different standards of care for

1 that?

2 A: I ... placement of sealants over frankly
3 cavitated decay, I think I testified that I
4 wouldn't do that in a private practice
5 situation where I knew the patient was
6 returning for treatment.

7 Q: And why would you do it in a public health
8 setting?

9 A: Simply because you don't know if the patient is
10 ever going to come back.

11 MR. WOODINGTON: I think that's all I have, Mr.
12 Chairman.

13 CHAIRMAN RAWLS: Thank you, Mr. Woodington.

14 MS. BALLARD: I have nothing on re-direct, but Dr.
15 Simonsen is available to answer any questions
16 the panel may have.

17 CHAIRMAN RAWLS: Does the panel have any questions
18 for Dr. Simonsen? (No response.) You're
19 dismissed. Thank you for your testimony.

20 MS. BALLARD: Thank you, Dr. Simonsen. If I could,
21 Mr. Chairman, the disclosure of this e-mail,
22 which we have just obtained copies of, raises
23 a fairly serious issue that I feel needs to be
24 brought to the attention of the panel. If this
25 is in fact an e-mail from Dr. Sneed, it

1 reflects that he's had ex parte communications
2 with investigators from the Dental Board
3 regarding these cases and that he has been
4 supportive of the Dental Board's efforts to
5 shut this enterprise down. We are deeply
6 concerned about the State using an expert
7 witness who has had ex parte communications
8 with, as he says here, "two Board
9 investigators," and we would request that the
10 entire testimony of Dr. Sneed be stricken.

11 MR. WOODINGTON: If I can address that, Mr. Chairman,
12 I don't ... there is no such thing as ex parte
13 communication with a Board investigator. If
14 the Board wants to investigate a case and needs
15 to talk to an expert, they send the
16 investigator out to talk to the expert, as is
17 the case with Dr. Sneed. If we had Board
18 members talking to Dr. Sneed, that would be a
19 completely different issue. If we had members
20 of this panel going down to Charleston to talk
21 to Dr. Sneed, that would be a different issue.
22 But what we have here is Board investigators
23 seeking an expert to pass an opinion on the
24 practices we've seen in these cases.
25 Obviously, that is completely not only

1 appropriate but ... not inappropriate ... but
2 the best thing they could do.

3 MS. BALLARD: Well, I also think it should be
4 introduced into evidence, at a minimum, because
5 I certainly questioned Dr. Sneed about whether
6 or not he had taken the position on the
7 efficacy of the school-based sealant program
8 and he said he had not, although he made some
9 pretty seriously false allegations regarding
10 the school-based program in this e-mail to Dr.
11 Simonsen. This is an incredibly inflammatory
12 statements that have been made by Dr. Sneed
13 concerning the employer of these hygienists,
14 and I think it's ... the statute does
15 specifically prohibit any communications with
16 the Board by third parties. Dr. Sneed says,
17 "the Board is receiving complaints from
18 dentists and the Board's concerns are these."
19 And I think it is highly inappropriate that
20 he's been offered as a witness in this
21 proceeding and I would move that his testimony
22 be stricken. I would also like to introduce
23 this into evidence unless it's necessary for
24 him to identify it. I believe it's been
25 represented that these are, in fact, statements

1 by Dr. Sneed, and I would offer them into
2 evidence at this point.

3 CHAIRMAN RAWLS: Have any objection to it being ...

4 MR. WOODINGTON: I don't object to it coming into
5 evidence.

6 CHAIRMAN RAWLS: Okay.

7 MS. BALLARD: For purposes of my motion to strike Dr.
8 Sneed's testimony and for no other purpose.

9 (Respondents' Exhibit Number Twelve was entered into
10 evidence.)

11 MS. BALLARD: I would renew my motion that Dr.
12 Sneed's testimony be stricken in it's entirety
13 by virtue of his ex parte communications with
14 the Board.

15 MR. ROSEN: I don't think that I would recommend that
16 we strike his testimony because it's routine
17 for investigators to develop their cases by
18 contacts with experts as well as other fact
19 witnesses. However, if the document that's
20 been introduced does have comments that relate
21 to potential contacts that are other than in
22 the development of the prosecution of this
23 case, that would be interesting to the panel
24 and we might have to consider that. Not having
25 seen it, we need to look at it.

1 CHAIRMAN RAWLS: We haven't seen it and we haven't
2 seen the inflammatory statements that you
3 mentioned.

4 MS. BALLARD: Well, the one that distresses me most
5 significantly is Dr. Sneed's description of the
6 HPS program as billing Medicaid and it is quite
7 lucrative and widespread. They have a dentist
8 on staff for practical purposes in name only.
9 If this information has been shared with the
10 Board, these entire proceedings cannot be
11 supported at all.

12 (Off the record discussion)

13 CHAIRMAN RAWLS: Ms. Ballard, is this the court
14 reporter's original?

15 MS. BALLARD: Yes.

16 CHAIRMAN RAWLS: The panel will take this information
17 under consideration but will not strike Dr.
18 Sneed's testimony. Your motion is denied but
19 we will take this under consideration.

20 MS. BALLARD: Will the motion be ruled on before the
21 panel issues a report and recommendation?

22 MR. ROSEN: I think he's ruling on it now.

23 CHAIRMAN RAWLS: We're ruling on it now, yes.

24 MS. BALLARD: I thought he said he was taking it
25 under consideration.

1 MR. ROSEN: The information contained in this, that
2 Dr. Sneed has placed in this e-mail, will be
3 part of their considerations in determining the
4 outcome of this case.

5 MS. BALLARD: Is the panel ruling that the ex parte
6 communications with the Board are appropriate?

7 MR. ROSEN: We don't know that there are ex parte
8 communications with the Board as the basis of
9 this. There may be communications from
10 investigators that are the basis for this.

11 MS. BALLARD: Well, you can read it as well as I can.

12 CHRISTINE VESCHUSIO, being duly sworn, testifies as
13 follows:

14 MS. VESCHUSIO - DIRECT EXAMINATION BY MR. COLEMAN:

15 Q: Would you state your name for the record?

16 A: Christine Veschusio.

17 Q: And where are you employed?

18 A: South Carolina Department of Health and
19 Environmental Control.

20 Q: What are your duties there?

21 A: I'm the coordinator for the School Dental
22 Prevention Program in the Oral Health Division.

23 Q: How long have you been doing that?

24 A: Three years.

25 Q: Give us a little history about some statistics

1 that you keep account of there. The incidence
2 of decay in our public school system, can you
3 discuss that with the Board?

4 A: Yes. We know, according to our 2001 oral
5 health needs assessment that was done by Dr.
6 Ray Lala, under his leadership, our then dental
7 director, using the basic screening survey
8 which is from the American ... the Association
9 of State and Territorial Dental Directors, that
10 one out of three children in South Carolina in
11 kindergarten and third grade brought together
12 have untreated dental decay. When we look at
13 these children according to race and
14 socioeconomic status, there are huge
15 disparities. When we look at our rural
16 communities, it is sometimes one out of two
17 children that are in schools with untreated
18 dental decay.

19 Q: Okay. And as part of your duties, you
20 coordinate the school-based program, is that
21 correct?

22 A: Uh-huh (affirmative response).

23 Q: And there's certain legislation that sets forth
24 criteria by which they have to adhere to with
25 DHEC, is that correct?

1 A: Yes. The legislation, the 2003 Dental Practice
2 Act, is what we adhere to that created the DHEC
3 Dental Public Health Program, and our program
4 adheres to the law as it stands today.

5 Q: Okay. And that's part of your duties?

6 A: I coordinate the program.

7 Q: Right. And you also are familiar with
8 documentation that is set forth by the
9 legislature that has to be complied with by
10 Tammi and the ... and her organization, is that
11 correct?

12 A: Yes. Tammi and we have ... and eight other ...

13 Q: And the other people in the state, right.

14 A: ... school dental prevention programs.

15 Q: And part of that is what they call a Memorandum
16 of Agreement, is that correct?

17 A: Yes.

18 Q: I want to ask you if you can identify that
19 document. I do not have a separate document
20 ...

21 MS. BALLARD: That's all right. It's already been
22 introduced into evidence.

23 MR. COLEMAN: Has it?

24 MS. BALLARD: It is Exhibit Number ...

25 COURT REPORTER: Six.

1 MS. BALLARD: Six.

2 MR. COLEMAN: Who's got that?

3 Q: All right. I want to show you ...

4 MS. BALLARD: It's behind tab three.

5 Q: That's Respondents' Number Three and ask you if
6 you can identify that document?

7 A: Yes.

8 Q: What is that?

9 A: You want section number three? I'm sorry.

10 Q: Well, no, that's Exhibit Number Three and what
11 is that document?

12 A: This is a memorandum of agreement between DHEC
13 and this program, Health Promotion Specialists.
14 This is the same memorandum of agreement that
15 exists for all our school dental prevention
16 programs.

17 Q: And is that the memorandum of agreement that
18 you have with the Health Promotion Specialists,
19 is that correct?

20 A: Yes, it is.

21 Q: All right. And as a result of that, I bring
22 your attention to the second page at the top.
23 And in that agreement you cite the guidelines
24 as set forth, is that correct?

25 A: Yes.

1 Q: And I think the guidelines is marked as Exhibit
2 Number Five in y'all's handbook, and if you
3 can, discuss the guidelines and how the
4 guidelines came about.

5 A: The guidelines were developed as a consensus
6 document. They actually were developed in 2001
7 through a large group we had as part of the
8 State Department of Education, had received
9 funding through the Centers for Disease Control
10 and developed an oral health coalition. This
11 group was a combination of many of the stake
12 holders throughout the state including the
13 Dental Association, the Dental Hygiene
14 Association, DHEC, and the State Department, it
15 had, of Education, were leaders in this group
16 but there were also other groups such as
17 advocacy groups for children with special
18 health care needs, education administrators, et
19 cetera.

20 Q: Okay. And specifically on page four, are you
21 aware of the criteria set forth about sealant
22 use, is that correct?

23 A: Yes.

24 Q: And that's entitled, Critical Scientific Facts
25 Related to Sealant Use, is that correct?

- 1 A: Our consensus document utilized the 1994
2 Sealant Workshop, which is the public health
3 document that is utilized for school sealant
4 programs. And that document has served to
5 guide all school dental, I would say pretty
6 much all school dental prevention programs
7 throughout the United States, particularly here
8 in South Carolina. And the only upcoming
9 change is the consensus document that we will
10 be receiving from the Centers for Disease
11 Control, we're waiting to receive that.
- 12 Q: And as far as the Health Promotion Specialists,
13 have they complied with the guidelines as set
14 forth in that document with DHEC?
- 15 A: Yes.
- 16 Q: With every aspect of it?
- 17 MR. WOODINGTON: Mr. Chairman, I object to that
18 because if it deals with tens of thousands of
19 patients, I don't know how she can possibly
20 answer that question.
- 21 MR. COLEMAN: I'm talking about internally as it
22 relates to DHEC, have they complied with
23 everything.
- 24 A: May I respond?
- 25 Q: Sure.

1 A: Please remind ... I'd like to remind you that
2 I as DHEC am the coordinator of the program.
3 I have no ... we don't have clinical
4 supervision, so I think what you're asking, we
5 coordinate a program; we have a memorandum of
6 agreement, and HPS complies with the memorandum
7 of agreement.

8 Q: Right. And if you would, look on page 4, where
9 it is entitled, Critical Scientific Facts
10 Related to Sealant Use.

11 A: I don't have the guidelines, but I know them
12 pretty ...

13 Q: If you would, just read that.

14 A: "Sealants have been demonstrated to be a safe
15 and effective long-term method to prevent pit
16 and fissure caries." There is documentation
17 obviously in the bibliography for this. "Pit
18 and fissure caries attacks begins in early
19 childhood and continues through adolescence and
20 into adulthood. In addition to preventing
21 carious lesions, sealants can arrest caries
22 progression. Effective sealant use requires
23 meticulous application technique, particularly
24 moisture control. Sealant retention should be
25 checked within one year of application." Do

1 you want me to continue?

2 Q: Right, please.

3 A: "Dental Sealants. All patients that have teeth
4 with structural characteristics that place them
5 at risk for decay should be considered for
6 preventive sealants. Patients that have teeth
7 with questionable decay should also be
8 considered for sealants, therapeutic sealants.
9 A third type of sealant, dental sealant,
10 interim sealant, may be used in community and
11 school-based programs. These sealants are used
12 to slow down the decay process in some teeth
13 that have dentinal caries. Interim sealants
14 are not recommended unless a dentist examines
15 the patient and determines that the patient is
16 unlikely to access restorative services in the
17 near future and the size of the lesion is not
18 too large to preclude this procedure.
19 According the procedure, the workshop on
20 sealant guidelines, the goal of preventing
21 caries through widespread use of sealants will
22 be accomplished best by providing preventive
23 sealants to individuals at high risk and
24 placing therapeutic sealants on carious lesions
25 that are limited to enamel."

1 Q: And how did these guidelines come about? Who
2 all was there and had input into the
3 guidelines?

4 A: The consensus group that I mentioned in 2001
5 developed these guidelines.

6 Q: Okay. And this is a fairly new organization as
7 far as going to the schools and doing this, is
8 that correct, as far as DHEC keeping records
9 and that type stuff?

10 A: Yes, it is. They did not come under DHEC until
11 2002.

12 Q: Have y'all begun to keep records on the number
13 of kids seen?

14 A: Oh, absolutely, yes.

15 Q: And do you also have a mechanism by which you
16 can keep a record of kids who participate in
17 this program and also the ones that follow up
18 with dentists?

19 A: Yes. Just for clarification, all children in
20 our program are referred to a dentist,
21 irregardless if they have no caries. So there
22 is three classifications that we utilize; and
23 zero means they need a referral for regular
24 dental care, which means an examination as they
25 do not receive a dental examination in our

1 school program; a one, they have caries, early
2 caries, which means we want them there within
3 a month. And urgent dental needs, which we
4 call a 2, means they have to get there, we hope
5 within 24 hours. And we do track by the
6 memorandum of agreement, we are tracking the
7 2's. And we are getting ... that has been a
8 challenge for our program, getting dentists to
9 see the children, but we are making progress.
10 The referral rate is consistently going up.

11 Q: Okay. What percentage of children that
12 participate in the program end up going to a
13 dentist, if you know?

14 A: I can't give you an exact figure but I am going
15 to say it's under 50 percent, but it steadily
16 has been rising.

17 Q: Okay. Rising over time?

18 A: Yes.

19 Q: Okay. I also want to show you, I think it's
20 already into evidence, Exhibit Number Six, and
21 ask you if you can identify that.

22 A: This is the decision tree for pit and fissure
23 treatment that was established by the 1994
24 workshop on dental sealants for public health
25 programs.

1 MR. WOODINGTON: Where would we find that?

2 MR. COLEMAN: That's Number Six in y'all's tab six.
3 It's supposed to be.

4 MR. WOODINGTON: Okay.

5 A: This was a large workshop. It's published in
6 the Journal of Public Health and has stood its
7 ground because the research has been upheld in
8 that time.

9 Q: And if I can take your attention more
10 specifically to the evaluation of pit and
11 fissure surfaces, can you explain that to the
12 Board?

13 A: The decision tree is in the evaluation of ...
14 actually begins with a risk assessment, which
15 is extremely important, and we use a risk based
16 approach. And then once an individual has been
17 ... the risk assessment has been accomplished
18 on the individual, we look at certain things
19 such as socioeconomic status and we know that
20 our poorer children have more disease, so
21 obviously that's going to put them at more risk
22 as an individual. Then we look at teeth and
23 that's the next step, and look at the
24 morphology, if there's deep, you know, grooves
25 in the teeth, et cetera, level of caries

1 activity, caries pattern. And you can see it,
2 you have immediately right, do not seal if the
3 tooth cannot be isolated, proximal restoration
4 involves pit and fissure surfaces, the life
5 expectancy of the primary tooth is short. And
6 then when you look down, evaluate for pit and
7 fissure sealants, they can be caries-free,
8 which would automatically be a sealant.
9 Questionable is advise, and this is public
10 health programs and not private practice
11 dentistry, and I can't emphasize how different
12 these situations can be. Enamel caries, seal;
13 and then if it's into the dentin, restore. And
14 then, you know, so that continues on down;
15 seal, if at risk for caries based on
16 evaluation; and do not seal, monitor if the
17 individual and teeth are not at risk. So this
18 is the basic guidelines that have been
19 established. These are not ... I'm not a
20 dentist. I don't ... these are the guidelines
21 that were established through consensus of a
22 group for our program.

23 Q: Okay. A couple follow-up questions. How has
24 DHEC's reaction been to this program?

25 A: Well, it's been positive, that they actually,

1 as far as the agency is concerned, it's been
2 positive. We have had a lot of positive
3 feedback from our constituents. As a
4 coordinator going out, school nurses, the
5 parents, the children, I mean I think it has
6 received a lot of positive feedback. We
7 conduct parent surveys and school
8 administration surveys throughout our program
9 and it's ... we have very positive feedback.

10 Q: And of course, Health Promotion Specialists, I
11 mean you're aware of that organization, are you
12 not?

13 A: Yes.

14 Q: Tammi?

15 A: Yes.

16 Q: And her partner who is sitting back there. And
17 needless to say, she is in constant contact
18 with you to ensure that they are complying with
19 the necessary guidelines, is that true?

20 A: Uh-huh (affirmative response).

21 Q: And she is aggressively pursuing what needs to
22 be done legally, is that correct?

23 MR. WOODINGTON: Object to the leading, number one.
24 Number two, while I don't object in theory,
25 this is just sort of a long drawn out character

1 witness for the hygienist, I guess, rather
2 relative to the standard of care issue.

3 CHAIRMAN RAWLS: Sustained.

4 MR. COLEMAN: That's all I have.

5 CHAIRMAN RAWLS: Okay. Thank you. Mr. Woodington.

6 MR. COLEMAN: Answer any questions Mr. Woodington may
7 have.

8 MS. VESCHUSIO - CROSS EXAMINATION BY MR. WOODINGTON:

9 Q: I just want to identify that this decision tree
10 for pit and fissure treatment, that's a DHEC
11 document?

12 A: No. That is ... that is actually from the
13 Journal of Public Health, the workshop
14 document, and it is not in ... it is not in our
15 ...

16 Q: Do you accept it?

17 A: Oh, yes, I definitely accept it. It isn't in
18 our program manual. That's what I was saying.

19 Q: Do you notice that the questionable area lies
20 between caries-free and enamel caries which
21 would be on the surface area?

22 A: Yes.

23 Q: There's no questionable area between enamel
24 caries and dentin caries, is there? I can show
25 you this document.

1 A: Here, I've got mine here.

2 Q: That's not where the questionable area lies, is
3 it, between ... it's not between enamel and
4 dentin. It's between no caries and enamel
5 caries?

6 A: Well, the question, yeah, caries-free,
7 questionable is if there is no ... if they
8 don't have ... there's a groove of stain, that
9 would be questionable. They don't know whether
10 there's enamel caries there or they don't know
11 where ... you know what I mean?

12 Q: Right.

13 A: I don't know if I'm clear on that but ...

14 Q: I think that's all I have. Thank you.

15 CHAIRMAN RAWLS: Any other panel members have any
16 questions? I've got a couple of questions. I
17 would assume, Chris, that all of these
18 guidelines and so forth are in accordance with
19 the Dental Practice Act and Regulations?

20 A: Yes, they are.

21 CHAIRMAN RAWLS: And the other thing is in the
22 guidelines on page four where it talks about
23 three types of sealants -- preventive,
24 therapeutic, and interim. It says the interim
25 sealants are not recommended unless a dentist

1 examines the patient and determines that the
2 patient is unlikely to access restorative
3 services in the near future. Is that
4 happening?

5 A: That the dentist examines the patient?

6 CHAIRMAN RAWLS: Right.

7 A: It depends on the program.

8 CHAIRMAN RAWLS: These, of course, are just
9 guidelines?

10 A: Uh-huh (affirmative response). They have
11 standing orders that they ... they have a
12 supervising dentist that would really supervise
13 ... would provide clinical supervision.

14 DR. COOMBS: I have a question. In the decision tree
15 for the pit and fissure treatment, you said
16 that is not a DHEC document, but it is endorsed
17 by DHEC?

18 A: Yes. It is part of the workshop and it just
19 doesn't happen to be in our manual.

20 DR. COOMBS: Okay. When you get down to the decision
21 tree where you have caries-free, questionable,
22 enamel caries -- the decision where to seal or
23 not seal, you get to dentin caries. The
24 response there is to restore and not place a
25 sealant, is that correct, and that's what DHEC

1 endorses?

2 A: Well, these were the guidelines that were
3 brought into, yes, our consensus document. You
4 know, this is what we use to guide our program.

5 DR. COOMBS: Okay. Thank you.

6 MS. BAKER: I have a quick question, too.

7 A: Sure.

8 MS. BAKER: Going back to the interim sealants and
9 the therapeutic sealants, we talked about a
10 dentist making the decision. Are you talking
11 about the dentist that they refer to or is
12 there a dentist that is ever there?

13 A: That is specific to programs, and in this
14 program, no.

15 Q: So they just refer to a list of dentists?

16 A: Yes.

17 CHAIRMAN RAWLS: Thank you, Chris.

18 MS. BALLARD: We would call Anonymous No. 1. Would
19 we need a break before she starts? She's the
20 Respondent. Are you okay?

21 CHAIRMAN RAWLS: Does anybody need a break? We might
22 take five minutes.

23 MS. BALLARD: Okay.

24 (Off the record, 5:02 p.m. to 5:10 p.m.)

25 ANONYMOUS NO. 1, R.D.H., being duly sworn, testifies

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1 as follows:

2 ANONYMOUS NO. 1 - DIRECT EXAMINATION BY MS. BALLARD:

3 Q: Anonymous No. 1, would you state your full name
4 for the panel?

5 A: Anonymous No. 1.

6 Q: Where do you live?

7 A: I live on Johns Island, South Carolina.

8 Q: What is your profession?

9 A: Registered dental hygienist in the public
10 health setting.

11 Q: What is your educational background?

12 A: I have a B.S. degree from the Medical
13 University of South Carolina, College of Health
14 Sciences.

15 Q: In what year?

16 A: In 1981.

17 Q: And since 1981, how have you been employed?

18 A: I stayed home for ten years with my three
19 children and once I got the baby in school, I
20 started work in 1990, worked for Dr. James
21 Decker, then worked for Dr. Thomas Weir, and
22 then worked for the Medical University of South
23 Carolina, the Hospital of Clinical Dentistry
24 where we saw in time patients that were very
25 sick.

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1 Q: Okay. So that was from 1990 through when?

2 A: I'm sorry, 1991 to '94 was Dr. Decker and Dr.
3 Weir, in '94 to 2001 was Medical University,
4 and then from 2001 to present with HPS.

5 Q: Okay. How did you make the decision to join
6 HPS?

7 A: The truth is it was decided for me.

8 Q: How is that?

9 A: I believe it was divine intervention. I wanted
10 to be a hygienist because I wanted to work with
11 children. I wanted to be a school hygienist
12 and at the time, there was no such thing. And
13 I thought wouldn't that be a neat occupation.
14 Not long after I had said that, a resume came
15 in the mail saying that we were looking for
16 hygienists to work in the schools, and I
17 submitted my resume and from what I understand,
18 there was a stack of them and I was chosen. So
19 that's why I said that.

20 Q: And have you worked with HPS consistently since
21 then?

22 A: I have.

23 Q: What is your job with HPS; what do you do?

24 A: My job with HPS is to take portable equipment
25 and take it into the school and see children

1 whose parent has filled out a consent form
2 giving them permission to be seen by me. And
3 they will come in and we do a patient
4 education; we do ... we talk about their home
5 care and do an assessment, diet and find out a
6 lot about them; and then I do an exam and then
7 determine what they need as far as their
8 cleaning; and do fluoride and then do sealants.

9 Q: In the course of your employment with HPS, have
10 you been provided with continuing education in
11 the field of sealants and other areas as well?

12 A: Incredibly so.

13 Q: Describe that for me.

14 A: Well, I came from the background that you just
15 did not seal anything but a tooth that has not
16 lost any integrity in the enamel. I've never
17 heard of therapeutic or interim sealants and so
18 this information was coming to us that this is
19 the ... there is a new school of thought from
20 what I was accustomed to and it was ... it was
21 very difficult to accept it until I kept
22 reading and reading and more information was
23 coming out. Then I began to understand that
24 this was something that I had an obligation to
25 do.

1 Q: In addition to the materials that are provided
2 to you by HPS, do you also independently
3 subscribe to publications of the Dental
4 Hygienist Association?

5 A: I do. RDH, Compendium, Access, all of those,
6 but I did not find that they had as much
7 information on dental sealants. The new school
8 of thinking, I found more in the Journal of the
9 American Dental Association.

10 Q: The Journal of the American Dental Association.

11 A: Yes.

12 Q: Is the setting working in the schools different
13 than you found in private practice?

14 A: Incredibly so, incredibly different.

15 Q: How?

16 A: There is a feeling when a child is in my chair
17 or a person is in my chair and the dentist is
18 in the next room, there's a feeling of security
19 that I have, a feeling that we're together and
20 this child's going to be okay. As I said in
21 the beginning, the reason I ... one of the
22 biggest reasons, because I love children and
23 there's this sense that they're going to be
24 okay, they're going to be taken care of, the
25 dentist is in the next room. Not only is he in

1 the next room, he's going to come in and look
2 at this child.

3 Q: So in terms of taking time with the students,
4 what restrictions are you under when you see a
5 student in the school setting?

6 A: Absolutely none. And that is definitely a plus
7 for this program. I have seen so many children
8 that are scared to death, and there is no
9 appointment; I don't go to school in the
10 morning and say, okay, I'm going to see Bobby
11 at 9:00 and Sarah at 10:00, et cetera, et
12 cetera. I go in and say these kids are free.
13 They don't go to lunch until 12:00. I'm going
14 to start with the first child in the class.
15 The second child in the class has no idea that
16 I'm going to call them. No one knows. If I
17 were to be absent that day, no one would even
18 know that they had an appointment. I make that
19 decision based on what's going on, who's not on
20 a field trip, et cetera. If that child is
21 scared, I take all the time in the world with
22 him. He can play with the instruments. We do
23 everything so that when that child is finished
24 with me, not only do they love me, they are
25 happy and they're not scared. That is a goal

1. of mine.

2 Q: And what services do you provide other than
3 education when you see a student?

4 A: Well, I do a cleaning, of course, but the whole
5 process that when I'm with this child is
6 education. I give them a mirror and I say,
7 now, let's get started; we're going to do this
8 together; you hold the mirror, and then I talk
9 about things. We point out teeth. This is
10 your twelve year molar or, you haven't gotten
11 this tooth yet, you will. Or the reason this
12 flap of tissue is there is because the tooth
13 hasn't come. Anyway, they get an incredible
14 educational experience. Then I show them what
15 the scaling is about, and I'm just going to
16 remove this; do you notice that most of the
17 plaque is under the gum line, it's not down
18 here. Then we go through the polishing and I
19 talk about the sealants. I even put a little
20 drop there and put the curing light and let
21 them see the difference of it being a liquid
22 and then a solid.

23 Q: You okay?

24 A: I'm good. I'm just so excited about this
25 program. I just go, ah. I mean, I could talk

1 all night about it, I'm sorry.

2 Q: Okay. In addition to cleaning the teeth, do
3 you provide fluoride treatments?

4 A: Yes. We have a fluoride varnish that we paint
5 on their teeth.

6 Q: And what kind of training have you received
7 with HPS or otherwise, in addition to what
8 you've told us about before in reading the
9 literature, in determining how to decide where
10 to place a sealant on a tooth?

11 A: We've had numerous information that comes to
12 us, and a lot of times it comes in the mail.
13 I'll have to say I'll get a packet in the mail
14 and it's the newest information that comes out.
15 But we did have the director, it was the
16 director at the time for DHEC, and he did come
17 and talk to us about the different types of
18 sealants. And again, this was brand new
19 information to me when he talked about the
20 different sealants. That's all.

21 Q: Okay. You had occasion to see both T.M. and
22 M.A., is that correct?

23 A: That's correct.

24 Q: I'm going to show you Exhibit Number Six. This
25 is State's Exhibit Number Six, which is the

1 chart for T.M., is that correct?

2 A: That's correct.

3 Q: Is that your chart for T.M.?

4 A: That's my chart.

5 Q: Okay. Would you walk us through what this
6 chart reflects that you did when you saw T.M.
7 on 2/17/04?

8 A: First of all, I would say that there is no, as
9 you know, there's no markings whatsoever on
10 here. The reason being at first we were told
11 we couldn't do that, that that was like
12 diagnosing. And so under further exploration
13 of that, we found out that hygienists do ... a
14 hygienist diagnoses. And so I was able to
15 after that, I think it was a couple of years
16 later, able to mark where I saw ... I would put
17 red or blue as appropriate. I did put that on
18 three, that there was decay on 3 and so I only
19 sealed a part of 3.

20 Q: Let's walk through this.

21 A: Okay.

22 Q: On this line that says 2/17/04, tell us what
23 this says that you did.

24 A: Okay. I reviewed the medical history and let's
25 see, I did a prophylaxis with fluorides, then the

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1 sealants. The NIC means that there was no
2 initial complaint. We'll ask the child does
3 anything hurt; does anything hurt when you chew
4 or when you eat something cold or hot. And the
5 child said no, no complaints. Everything's
6 good. And then the OHI is the oral hygiene
7 instructions. The 11 means that there was
8 decay present. The letter list sent meant that
9 I send a letter home to the parent explaining
10 what I did and that I saw decay. The list is
11 that I gave that parent a list of the dentists
12 in that area. And I usually highlight the
13 dentists, because we have lists of dentists
14 that are ... I mean, I could be from Edisto to
15 James Island to North Charleston, so I'm going
16 to highlight a dentist that's in their
17 community.

18 Q: Do you ever see a patient, M.A. or otherwise,
19 in which you don't send a letter home with the
20 recommendation that dental care be sought?

21 A: Absolutely not.

22 Q: All right. And you chose to seal what teeth
23 here?

24 A: All four of the first molars, the six year
25 molars, not sealing the mesial of number 3.

1 Q: Okay. So you only sealed part of number 3, is
2 that correct?

3 A: That's correct.

4 Q: Okay. But you sealed all of 14, 19, and 30,
5 correct?

6 A: That's correct.

7 Q: Do you recall this patient?

8 A: I do.

9 Q: Okay. What do you recall about her
10 socioeconomic background?

11 A: I remember she was a white child, she was in a
12 ... well, maybe I shouldn't say that much about
13 her. I don't know how much is privileged about
14 her.

15 Q: I understand.

16 A: Okay. So I won't say some of the things I
17 remember, but I do remember that her mother
18 said, and I don't even know if this is
19 attached, no, it's not. Her mother in the
20 consent form said that she did not have a
21 dentist.

22 Q: Okay. So when she left your hands after the
23 treatment that you had provided on 2/17/04,
24 what belief, if any, did you have that she was
25 going to receive follow-up dental treatment?

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1 A: None whatsoever.

2 Q: In your experience, when you send letters home
3 recommending dental treatment, do you have a
4 feel for how often the follow-up dental care
5 has in fact been sought, from your experience?

6 A: Yes. From my experience, because I, of course,
7 I see a lot of them every six months, so I
8 check on that. And I would have to say 40
9 percent.

10 Q: Forty percent do call the dentist?

11 A: Maybe.

12 Q: So 60 percent do not?

13 A: I would say yes.

14 Q: When you're making a determination as to
15 whether to put sealant on a tooth, how does
16 that experience factor into your determination
17 as to whether to seal a tooth?

18 A: I struggle and find that I am negligent if I
19 just leave it open and just leave it there and
20 not know if they're going to go to a dentist.
21 I struggle with that.

22 Q: Why is that?

23 A: Because my heart is to take care of that child.
24 And I just feel like it's just going to sit
25 right there and grow.

1 Q: If you don't seal it?

2 A: Uh-huh (affirmative response). Even with my
3 pitiful little contribution, I feel like I've
4 done something.

5 Q: So your option when you see a child like T.M.
6 is to seal or not seal, correct?

7 A: That's correct.

8 Q: Are there ever teeth that you don't seal?

9 A: Yes, there are.

10 Q: And describe those kind of cases for us.

11 A: There is usually maybe just the wall is
12 present.

13 Q: How would you describe the presence of caries
14 in a tooth like that that you don't seal?

15 A: Gross decay.

16 Q: You do not seal gross decay?

17 A: I do not.

18 Q: Okay. Let me show you Exhibit Number Four,
19 which is your chart on M.A. Would you walk us
20 through what you did on this chart, on this
21 child?

22 A: Again, I reviewed her medical history. This is
23 April 7th of 2003. I did a prophylaxis and fluoride
24 and did sealants. She had eight teeth, none
25 that were restored, and again found that the

1 distal of 30 was too large to place ... oh,
2 thank you, place a sealant, and I just remember
3 she had incredibly stained fissures, not that
4 I remember, I have that, and that there were
5 ... and this is another area of my learning,
6 the evolution of learning is that I say sticky,
7 but I couldn't ... there was literature that
8 said that if you really press one, you could
9 cavitate her, too. You can transfer bacterium
10 from one tooth to another, so I try to be
11 conservative about that.

12 Q: And you're aware that M.A. saw in fact a
13 dentist, saw Dr. Chadwick, within a month
14 later?

15 A: Yes, I am aware.

16 Q: Did you consider M.A. therefore to be a success
17 for the program?

18 A: Very pleased, very pleased.

19 Q: Why is that?

20 A: Because that is what I want. I want these
21 children ... I know I can only do so much and
22 I know they need more than what I can give.
23 And so to know that this child received care
24 was absolutely considered successful to me.

25 Q: Same question with T.M., are you aware that

1 T.M. in fact saw a dentist two weeks later,
2 correct?

3 A: Yes.

4 Q: Did you consider that to be a success?

5 A: I did.

6 Q: Is that an exception to the rule when you see
7 students that you treat actually get follow-up
8 dental care?

9 A: Yes, it is. As a matter of fact, some of them
10 will tell me when they see me in school, I went
11 to the dentist, and we high-five or, yeah. So
12 that ... yeah, that's what we want. And I
13 explain that to the child, too, now, you need
14 to go to a dentist and this is why and this is
15 what will happen if you don't.

16 Q: What equipment, if any, do you provide to the
17 students when you're finished doing the
18 examination, the cleaning, the fluoride, and
19 the sealants?

20 A: Equipment, I'm not sure what you're asking.

21 Q: Do you provide a toothbrush?

22 A: Oh, I go further than that.

23 Q: Tell me what you do.

24 A: I have, and this is why maybe my production is
25 down sometimes, is I have a little ... I give

1 them a bag and I put toothpaste in it, I put a
2 toothbrush in it, and I pay with my own money,
3 pencils. You can ask my husband, he's helped
4 me. We get like an assembly line, stickers,
5 and I get also information on sealants,
6 information on the importance of milk in their
7 diet. These are different things that I put in
8 there for them, and for the parent as well.
9 So, even the fluoride, the varnish, I put a
10 little thing in there that explains to the
11 parent that the varnish does not permanently
12 stain their teeth. It will come off when they
13 brush, and the instructions how to take care of
14 it. So those are pretty much standard what I
15 put in the child with the child.

16 Q: That's all I've got, Anonymous No. 1. Thank
17 you.

18 A: You're welcome.

19 Q: Mr. Woodington may have some, so I'm going to
20 leave these right here.

21 A: All right.

22 MR. WOODINGTON: I have just a very few questions.

23 ANONYMOUS NO. 1 - CROSS EXAMINATION BY MR. WOODINGTON:

24 Q: Anonymous No. 1, you don't deny that part of
25 your training is to enable you to recognize

- 1 tooth decay, isn't it?
- 2 A: That's correct.
- 3 Q: Okay. So you understand that's part of your
- 4 job, to be able to recognize tooth decay?
- 5 A: That's correct.
- 6 Q: Okay. How many school children do you think
- 7 you've seen? How many different school
- 8 children do you think you've seen since the
- 9 public school health program started?
- 10 A: I would say probably, and a lot of these could
- 11 be repeats, so let me think. Counting them as
- 12 repeats, I would say, let's see, one, two,
- 13 three, four, five, five thousand.
- 14 Q: Okay. Does that include repeats?
- 15 A: That includes repeats.
- 16 Q: That's the number of total ...
- 17 A: Right.
- 18 Q: ... patients including repeats?
- 19 A: Uh-huh (affirmative response).
- 20 Q: Do you have any kind ... if you don't, this is
- 21 fine, but do you have any kind of ballpark
- 22 figure of how many actual people that is?
- 23 A: It's five thousand ... oh, you mean if I'm not
- 24 including the repeats, to drop it down?
- 25 Q: Five thousand different people, is that what

1 you're guessing?

2 A: No, I'm not. So if you were to drop it down to
3 different people, maybe half that.

4 Q: Okay. Do you really have an independent
5 recollection, that is, can you recall these
6 children, M.A. and T.M.?

7 A: Absolutely.

8 Q: You can?

9 A: Yes.

10 Q: And what do you recall about them specifically?

11 A: T.M. was a small white female and M.A. was a
12 tall dark ... but I cannot remember if she was
13 African-American or white, but she was tall.
14 I think she was seventh grade and she had long
15 dark hair. And I think that's ... but I also
16 can remember that she did not have a dentist.

17 Q: Do you recall what the teeth looked like in
18 these children?

19 A: Yes, I do.

20 Q: Okay. What kind of tools do you use in your
21 practice to detect decay?

22 A: My lights and my mirror and my eyes and my
23 explorer.

24 Q: You use an explorer?

25 A: Yes.

1 Q: You don't use the thing that Dr. Sneed talked
2 about ...

3 A: Diagnodent? No, I never even heard of it until
4 today.

5 Q: Diagnodent. How about the ... I can't remember
6 the name, but the bright light that you shine
7 through.

8 A: The laser?

9 Q: No. It was a ...

10 CHAIRMAN RAWLS: Transilluminator.

11 Q: Transilluminator, thank you.

12 A: No, I do not.

13 Q: Okay. So it's your eyes and the explorer
14 pretty much?

15 A: Uh-huh (affirmative response).

16 MS. BALLARD: Say yes for the record.

17 A: Yes, I'm sorry, yes.

18 Q: That's all I have.

19 MS. BALLARD: I don't have any follow-up unless the
20 panel has questions.

21 CHAIRMAN RAWLS: Does the panel have any questions?

22 DR. JETT: Anonymous No. 1, do you remember on these
23 two particular patients, is one question; and
24 kind of follow-up, is it your habit when you
25 knew there was decay on these patients, did you

1 tell the mom, and I know it says you sent a
2 letter and a list was sent, did you tell the
3 mom and the child that there was decay
4 underneath the sealants?

5 A: I can't do that. I'm not allowed to say
6 there's decay at all. I have to call it an
7 obvious problem, and usually I get phone calls
8 from parents scared to death that the child has
9 a tumor or something. But I was told that we
10 were not allowed to call it decay but what I
11 would say to them, I wish that we had a form
12 here to show you, but what I would put ...
13 there's different things you can check. There
14 is no problem, please, you need to see your
15 dentist for an appointment and exam at least
16 once a year. The second thing is that your
17 child has decay ... your child has an obvious
18 problem and needs to be seen by the dentist,
19 and I highlight that and put a star by it. And
20 then I staple to it the list of dentists that
21 are in that area, and Dr. Chadwick was one of
22 the ones I highlighted for that.

23 DR. JETT: So that's how those children saw Dr.
24 Chadwick is by the letter that you highlighted?

25 A: I hope so. But as far as ... yeah, that's what

1 I do. That's my standard, is to ... the one
2 that's appropriate. Now, if there was one
3 where the child was in pain, if they say, oh,
4 this one is killing me, then I would check the
5 2 that Chris discussed and that is the one
6 where they need to be seen within 24 to 48
7 hours. So I did not. I checked the one where
8 they need to be seen within a month.

9 MS. BALLARD: May I show her the form that she was
10 trying to refresh her recollection with? It's
11 not in these cases but just the form that's
12 used.

13 MR. WOODINGTON: Sure.

14 MS. BALLARD: This is not one of yours. This is one
15 of Anonymous No. 3's.

16 A: If you have any questions, you can please ...
17 that's also on there, too. If you have any
18 questions, you can please contact me. I put my
19 name, my cell number and my name down here. If
20 you do not have a dentist, a list of dentists
21 that are in your area is attached for you to
22 choose from. If you've listed a dentist on
23 your consent form and your child needs an
24 appointment, we will send a note telling him or
25 her. So we even help them if they have a

1 dentist. Do you need us to help you get the
2 appointment? We really do anything we can to
3 get them going.

4 CHAIRMAN RAWLS: Any other questions?

5 DR. COOMBS: Do we have a copy of the letter that
6 was sent to either one of these individuals?

7 MS. BALLARD: No. The problem is that we're not
8 able to make copies of them. The hygienists
9 write out the letters and give them to the
10 students and we don't have access to copiers.
11 We do in a couple of the cases have letters
12 that were apparently provided by the students
13 or the students' parents to the treating
14 dentist that got forwarded to the Board, and so
15 in a couple of the cases I do in fact have
16 copies of the letters. But we don't have any
17 of the exact letters that Anonymous No. 1 sent
18 home with these patients.

19 A: You're talking about these?

20 DR. COOMBS: I guess. Whatever the letter lists as
21 ...

22 A: Right.. I send the form home and either the
23 parent ... now, I've had the parents take that
24 to the dentist. They've actually taken that
25 and said, look, this is what she told me. Some

1 of them, they may throw them away. I don't
2 know what they do with them. I hope that,
3 yeah. So that's all I know.

4 DR. COOMBS: Are these letters, are they off of a
5 standard form, that is reproduced as an
6 identical form or are they individual letters
7 specific to each patient?

8 A: No, this is a standard ... they're a standard
9 form, but these are forms that we have taken
10 and thought about and brain-stormed over the
11 best way to communicate. Our forms over the
12 years have changed because as we're in there
13 with the students, we begin to realize, wait a
14 minute, I don't think they're getting this,
15 let's change it. So we're constantly tweaking
16 these forms to make them more user friendly to
17 the parent. So this is a standard form, but we
18 believe that we've changed it and made it the
19 most understandable or comprehensible for the
20 parent.

21 DR. COOMBS: I guess my question. I'm trying to
22 ascertain a response is do you have a standard
23 form that you check off specific
24 recommendations and then those recommendations
25 are written out addressed to the parent?

1 MS. BALLARD: We can bring a blank form. The State
2 has introduced one in another case. I'll be
3 happy to show you the form where they fill in
4 the specifics as to the particular patient.

5 DR. COOMBS: That'd be good.

6 MS. BALLARD: Let me go make a couple of copies.

7 A: These are old. The ones that we do now are
8 different, are changed from that.

9 DR. COOMBS: Would this be a form similar to what
10 would have been used at the time?

11 A: This was 2002.

12 MS. BALLARD: Yeah, the ones she would have, I can
13 bring that tomorrow. I can go get it now, but
14 it will take me 20 minutes to go and get it or
15 I can have it for you ...

16 CHAIRMAN RAWLS: Bring it tomorrow.

17 MR. WOODINGTON: I'm okay with leaving the record
18 theoretically open to let that come in
19 tomorrow.

20 A: I'd like to add, too, that we're not supposed
21 to ... I would love to write all kind of
22 things, but that we would get in trouble if we
23 got out of our area of expertise, so we
24 basically checkmark.

25 DR. COOMBS: That's basically what I'm looking for.

1 A: Okay. Yeah, I would love to do that.

2 MS. BALLARD: We'll provide you with a copy of the
3 one we have today and then we'll bring a blank
4 one that would have been applicable when
5 Anonymous No. 1 saw these two patients.

6 DR. COOMBS: Okay, thank you.

7 CHAIRMAN RAWLS: You mentioned that you do a prophylaxis,
8 fluoride, and you mentioned fluoride varnish
9 specifically on students?

10 A: Yes, sir.

11 Q: In what order do you do those?

12 A: I would do the prophylaxis first. I would do the
13 sealant if applicable, second, and I would
14 finish with the fluoride. It's ... I noticed
15 you ... you probably see that it's written in
16 that order there, but that's not the order I
17 would go in.

18 DR. WADE: One question. At any point in time do you
19 use an assistant to help you place sealants or
20 do you do it just with your own two hands?

21 A: I do it with my own two hands.

22 DR. WADE: And then do you use a rubber dam to help
23 isolate or just with cotton rolls or ...

24 A: Basically, I found that cotton gauze works so
25 much better than cotton rolls. As a matter of

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1 fact, we had some students that came in and
2 observed and liked that method better. But
3 yes, just cotton rolls and the dry aids and the
4 cotton gauze.

5 DR. WADE: That's all.

6 CHAIRMAN RAWLS: Any other questions?

7 MR. WOODINGTON: None.

8 CHAIRMAN RAWLS: You're dismissed.

9 A: Thank you.

10 MS. BALLARD: That concludes the Respondent's case,
11 with the exception of introducing the copy of
12 the forms that we're leaving the record open
13 for that in Anonymous No. 1's case.

14 MR. WOODINGTON: Let me call Dr. Sneed back for just
15 a minute.

16 CHAIRMAN RAWLS: Dr. Sneed?

17 COURT REPORTER: Dr. Sneed, I just want to remind
18 you that you are still under oath.

19 DR. SNEED - RE-DIRECT EXAMINATION BY MR. WOODINGTON:

20 Q: Dr. Sneed, I have basically one question. This
21 relates to the e-mail that came in as
22 somebody's, I guess my Exhibit A or maybe their
23 Exhibit A. You referred to the Board as asking
24 what is the standard of care. Who did you
25 speak to specifically?

- 1 A: Rion Alvey and Jay Evans.
- 2 Q: And Rion Alvey is the executive director of the
- 3 Dental Board?
- 4 A: I believe that's right.
- 5 Q: And Jay Evans was an investigator for the Board
- 6 at that time?
- 7 A: My understanding.
- 8 Q: Have you ever spoken in connection with these
- 9 cases to any member of the Dental Board that
- 10 will eventually sit on this case?
- 11 A: No, sir.
- 12 Q: Past or present ... well, I should say the
- 13 present Dental Board that will sit on this
- 14 case, have you ever spoken about these cases
- 15 with any members of this panel?
- 16 A: No.
- 17 Q: What do you mean when you say the Board is
- 18 asking in that letter?
- 19 A: Well, two investigators from the Board showed
- 20 up in my office asking me questions and I
- 21 considered them representatives of the Board.
- 22 Q: Okay.
- 23 A: And I might add ...
- 24 Q: Let me ask this of you. Was your response then
- 25 to do sort of an e-mail query of your

1 colleagues?

2 A: Exactly.

3 Q: And is that what this is, one of the responses?

4 A: That is exactly correct.

5 Q: And can you tell me, it's in this e-mail, just
6 tell me exactly kind of what you were asking.

7 A: Well, I was asked by the investigators the
8 standard of care and whether putting sealants
9 over these lesions is the standard of care.
10 And I had my opinion, but I wanted to
11 corroborate that with experts and I knew Dr.
12 Simonsen and thought very highly, still I think
13 extremely highly of him, so I e-mailed him. I
14 e-mailed and talked to some other friends that
15 were at other schools about the standard of
16 care under these circumstances and if there was
17 a different standard of care, trying to
18 solidify and coalesce my understanding of the
19 standard of care, which was basically what I
20 already had determined in my own mind.

21 Q: And was the feedback you got on these e-mails
22 consistent with your opinions?

23 A: Yes, sir.

24 Q: And was your testimony consistent with that?

25 A: Yes, sir.

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1 Q: That's all I have, I think, for now.

2 MS. BALLARD: A couple of follow-ups, Dr. Sneed.

3 DR. SNEED - RE-CROSS EXAMINATION BY MS. BALLARD:

4 Q: Have you ever spoken to any member of the
5 Dental Board about the school-based dental
6 hygienist program?

7 A: Back in '86.

8 Q: Since then you've not had any communications
9 with any ...

10 A: Relative to this, no, ma'am.

11 Q: Not ... my question isn't relative to this. My
12 question is, the school-based dental hygienist
13 program.

14 A: No, ma'am.

15 Q: You've had no conversations at all?

16 A: No, ma'am.

17 Q: Let me refer back to the same e-mail that Mr.
18 Woodington was asking you about. It concludes
19 on page two a conversation that you had with a
20 Rob Kavorik?

21 A: Right.

22 Q: Am I correct?

23 A: Right.

24 Q: And would you advise the panel what it is that
25 Mr. Kavorik advised you the standard of care

1 was in a public health setting?

2 A: Sure. I'll just read the whole thing. I
3 talked to Rob Kavorik on the phone. They teach
4 if, after an exam, the dentist is on the fence,
5 it is okay to seal. They do not seal over
6 frank decay, but he feels that in a public
7 health setting it might be okay to place
8 sealants on everything. Socioeconomically
9 disadvantaged children might benefit.

10 Q: And that's signed by you; that's your summary
11 of his position?

12 A: That is correct. That is my interpretation of
13 what Rob Kavorik told me.

14 Q: That's all I've got. Thank you.

15 MR. WOODINGTON: I have nothing else. Okay. At this
16 point we rest. I don't know if you want to
17 hear closing arguments at this point in this
18 case or not, or should we ... or what?

19 MS. BALLARD: I would suggest we do closing
20 statements at the end of all the cases simply
21 for purposes of saving time. Just do one
22 closing statement for all.

23 CHAIRMAN RAWLS: Are all the cases similar in this
24 regard?

25 MS. BALLARD: Yes, they are.

1 MR. WOODINGTON: Let me tell you how we would propose
2 to proceed if okay. We have the witnesses here
3 for what we had hoped would be the 2:30 case.
4 Now, we're after 5:30, but all the 2:30 case is
5 going to consist of is the equivalent of Dr.
6 Chadwick standing up and talking about one
7 patient and what he saw as the treating
8 dentist. And then Dr. Sneed commenting, if he
9 can, on what he can see from the records and
10 the charts and the photos of that patient and
11 incorporating the rest of his testimony by
12 reference, if you will allow me to do the same
13 thing with him too.

14 MS. BALLARD: With Dr. Simonsen and with the
15 hygienist in that particular case, I would
16 guess that we could conclude, incorporating the
17 testimony from this case into the next case, we
18 can be finished in an hour.

19 MR. WOODINGTON: That's what I would think.

20 CHAIRMAN RAWLS: Which will allow closing statements
21 after all of the cases.

22 MR. WOODINGTON: Suits me.

23 MS. BALLARD: Great. Thank you.

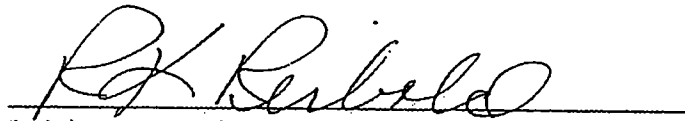
24 (There being no further matters, the hearing was
25 adjourned at 5:41 p.m.)

CERTIFICATE

This is to certify that the within panel hearing consisting of Two Hundred Seventy (270) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on August 23, 2006.



Robin K. Reibold
Court Reporter

Notary Public for South Carolina
My Commission Expires: May 11, 2011

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THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
STATE BOARD OF DENTISTRY

Docket No. 06-ALJ-11-0562-AP
[In Re: Case No. 04-45]
Docket No. 06-ALJ-11-0563-AP
[In Re: Case No. 03-104]

Anonymous No. 1, R.D.H., and Anonymous No. 2, R.D.H. Appellants,

v.

South Carolina Department of Labor, Licensing and Regulation,
South Carolina Board of Dentistry, ... Respondent.

CONSENT ORDER FOR JOINT RECORD ON APPEAL AND FOR
REDACTION OF RECORD ON APPEAL

In this case, the Board of Dentistry elected to issue an anonymous public sanction to the two Appellants, who are licensed dental hygienists. The parties have agreed to, and the Court approves, the following procedures to be used in connection with the Record on Appeal in these cases:

1. These cases and two others (not the subject of any appeal) were tried at the same set of hearings, with a stipulation that the evidence in any of the four cases could be

FILED

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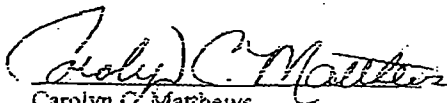
SC ADMIN. LAW COURT

used in any other of the cases. As a result, it is appropriate that there be only one Record on Appeal for these two cases, and the Court so orders. The record shall include all evidence arguably relevant to the two Appellants, but need not include such evidence as pertains solely to the two nonappealing hygienists unless necessary to make the record comprehensible to the Court.

2 In order for the confidentiality of the names of the anonymous Appellants, as well as the names of the nonappealing hygienists and the patients involved in these cases, the parties shall redact the names of the hygienists and of their patients from the Record on Appeal and from the briefs. Hygienists shall be referred to as "Hygienist 1," etc. Patients shall be referred to by their initials. With the review and consent of appellants, the Board may arrange for the court reporter(s) of the hearing to provide substitute transcripts with these redactions made, but the Board shall retain its original versions of the transcripts as they existed prior to redaction, with copy to appellants. The parties understand that the Court may require the Record on Appeal to be amended if there are difficulties in understanding which persons are being referred to.

3. The Record on Appeal shall be filed on or before August 21, 2006, unless this date is extended by the Court.

AND IT IS SO ORDERED.

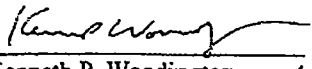

Carolyn C. Matthews
Administrative Law Judge

Columbia, South Carolina

August 22
2006

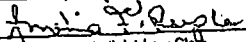
WE SO MOVE AND CONSENT:


Desa Ballard
Attorney for Appellants 7-28-06


Kenneth P. Woodington 8/1/06
Attorney for Respondent

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).

This 8th day of June 2006
By: 
Judicial Law Clerk

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
STATE BOARD OF DENTISTRY

Docket No. 06-ALJ-11-0562-AP
[In Re: Case No. 04-45]
Docket No. 06-ALJ-11-0563-AP
[In Re: Case No. 03-104]

Anonymous No. 1, R.D.H., and Anonymous No. 2, R.D.H. Appellants,

v.

South Carolina Department of Labor, Licensing and Regulation,
South Carolina Board of Dentistry, ... Respondent.

RECORD ON APPEAL - VOLUME II

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SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING & REGULATION
BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:)
ANONYMOUS NO. 2, R.D.H.) REVISED TRANSCRIPT
License No. 2540) WITH REDACTED NAMES
Respondent.) PURSUANT TO ORDER OF
-----) CAROLYN C. MATTHEWS,
) ADMINISTRATIVE LAW
) JUDGE, DATED
AUGUST 2, 2006
(Order attached)

PANEL HEARING

COPY

Friday, December 2, 2005
5:58 p.m. - 6:40 p.m.

The Panel Hearing before the South Carolina State Board of Dentistry was held at the Synergy Office Park, Kingstree Building, Room 113, 110 Centerview Drive, Columbia, South Carolina, on the 2nd day of December, 2005 before Robin K. Reibold, Court Reporter and Notary Public in and for the State of South Carolina.

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APPEARANCES**BOARD MEMBERS:**

Douglas S. Rawls, D.M.D., Chairman
 Ben Jett, D.M.D.
 Paul Coombs, D.M.D.
 Charles Wade, D.M.D.
 Deborah P. Baker, R.D.H.

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(Q.G. Records - Dr. Adams)	
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(3 Photographs)	
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STIPULATIONS

Upon stipulation and agreement by all parties, Petitioner's Exhibit Numbers One through Eleven and Fifteen through Twenty-three and Respondents' Exhibit Numbers One through Eighteen are to be incorporated into this hearing.

It is further stipulated and agreed that this hearing is being taken pursuant to the Administrative Procedures Act, the Practice Act and Regulations of the Board.

1 (Petitioner's Exhibit Numbers Twelve, Thirteen, and
2 Fourteen were admitted into the record upon agreement
3 by all parties prior to the hearing.)

4 BENJAMIN S. ADAMS, D.M.D., being duly sworn,
5 testifies as follows:

6 MR. WOODINGTON: By the way, Dr. Adams will be our
7 only witness on this one as it turns out,
8 unless something strange happens.

9 DR. ADAMS - DIRECT EXAMINATION BY MR. WOODINGTON:

10 Q: Dr. Adams, could you state your full name for
11 the record, please?

12 A: Benjamin Stanford Adams.

13 Q: Okay. And where do you live?

14 A: 10 Redfern Trail, Simpsonville, South Carolina,
15 29681.

16 Q: Okay. And you're a practicing dentist,
17 correct?

18 A: That is correct.

19 Q: And where do you practice?

20 A: I practice at 870 Cleveland Street, Suite 1A,
21 Greenville, South Carolina, 29601.

22 Q: Okay. Could you state your educational
23 background, please?

24 A: Sure. I have a bachelor's from Clemson
25 University and a D.M.D. from the Medical

1 College of Georgia.

2 Q: In Augusta?

3 A: That is correct, yes.

4 Q: When did you graduate from medical school, the

5 Medical College?

6 A: 1996.

7 Q: Okay. Did you go directly into dental practice

8 at that point?

9 A: Yes.

10 Q: What's the nature of your practice?

11 A: General dentistry.

12 Q: Have you been in practice by yourself the whole

13 time, or any of the time?

14 A: Yes. I was never an associate. I've always

15 had my own solo practice, but there was from

16 time to time a dentist or two who worked in the

17 same building as I.

18 Q: Okay. And are you here under subpoena today,

19 pursuant to subpoena?

20 A: Yes.

21 Q: Okay.

22 MR. WOODINGTON: Mr. Chairman, we'd offer Dr. Adams

23 as an expert in general dentistry including the

24 diagnosis and treatment of tooth decay.

25 MS. BALLARD: No objection.

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1 CHAIRMAN RAWLS: Okay.

2 Q: We're going to deal with just one patient and
3 that's a kid named Q.G. How do you pronounce
4 it?

5 A: Q.G. (ph.).

6 Q: Q.G. And he was a patient of yours, is that
7 correct?

8 A: He is a patient of mine, that is correct.

9 Q: He is still, okay. Do you remember his
10 approximate age in 2003?

11 A: He was approximately 12 years old.

12 Q: Okay. Let me interrupt myself for a minute.
13 We have three exhibits which consist of Dr.
14 Adams' chart, which is the first one; a series
15 of photographs that he took, which is the
16 second one; and the HPS records on this person,
17 on Q.G., which is the third and last exhibit.
18 Dr. Adams, I think you have your chart in front
19 of you, a copy of your chart?

20 A: Yes, I do.

21 Q: How about just walking us through this,
22 starting with the first entry and running
23 through the 10/7/03 entry.

24 MS. BALLARD: For the record, he's referring to
25 Exhibit Number Twelve.

1 A: Sure. Would you like me to begin at February
2 27th of 2003?

3 Q: Might as well, go ahead.

4 A: Okay. On February 27th of 2003, I met Q.G. for
5 the first time for an initial exam. My
6 hygienist performed a child prophylaxis and
7 fluoride. We took four bitewings that day and
8 my hygienist noted that he had heavy plaque and
9 moderate black subcalculus. She oral hygiene
10 instructed, including how to use toothbrush,
11 floss and rinse, fluoride rinse.

12 Q: Okay. And I see the notes down here just a few
13 days later on 3/4/03, what happened then?

14 A: That is correct. Q.G. came back. Let's see,
15 I gave him some anesthetic, extracted root tips
16 on tooth number J, a primary tooth. I gave him
17 and his mother post-operative instructions for
18 the care of that. And also I did a composite
19 restoration on tooth number 30; it was an
20 occlusal composite using Fuji GC liner, and I
21 might just add that whenever I use GC liner
22 that means it's deep and it's close to the
23 nerve, so I'm protecting the nerve. Prime &
24 Bond, that is the adhesive that is used for
25 composite restoration and Heliomolar Flow A2,

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1 that is the composite restoration. Heliomolar
2 is the brand; Flow is flowable; A2 is the
3 color.

4 Q: All right. Now, let's move onto 9/2/03.

5 A: Sure. Q.G. came back for his second prophy.
6 So I did an exam. We had the child prophy,
7 fluoride, and my hygienist noted again moderate
8 heavy plaque with moderate calculus. And this
9 was only six months and five days after his
10 initial cleaning. And we also noted at that
11 time that the patient had rampant decay. And
12 at that appointment I put down, next visit,
13 that's the NV; 2-0, meaning occlusal; 3-0; 4-0;
14 and 5, sealant. That was what I was going to
15 be doing, three restorations, three composite
16 restorations and one sealant, and his mother
17 scheduled at the end of that appointment for
18 him to come back on 10/7/03.

19 Q: Okay. Let's jump up. I think this little ...
20 it's actually a photocopy of a card, is it not,
21 that's sort of on the top half of this exhibit?

22 A: That is correct. That is our treatment plan
23 card that in doing the exam on a patient, my
24 hygienist will have that card in her hand and
25 I will call out any restorations that need to

1 be done. And on 9/2/03, because ... well,
2 3/4/03 we had done extraction of root tips and
3 a restoration on number 30. Since that time,
4 he had this rampant decay for some reason and
5 I had had my hygienist write down everything as
6 I was calling it out that I diagnosed.

7 Q: Okay. And with specific reference to tooth
8 numbers ... the molars.

9 A: Uh-huh (affirmative response).

10 Q: Can you go ahead and tell me what you diagnosed
11 on those?

12 A: Sure. Diagnosed decay on number 2 and 3,
13 number 14, number 15, number 18, number 19,
14 number 30 and 31. Those were all first, all of
15 his first and second permanent molars. The
16 third molars were not in his ... had not
17 erupted at the time.

18 Q: What were you proposing as a treatment plan for
19 those teeth at that time? This is 9/2/03
20 again.

21 A: Sure.

22 Q: Just read it one by one, I guess go through it
23 one by one for the ones you just read.

24 A: Okay. Just for the ones I read ...

25 Q: For the molars.

- 1 A: Okay. On number 2, I had down an occlusal
2 composite; 3, occlusal composite; 14, occlusal
3 composite; 15, occlusal composite; 18, occlusal
4 composite; 19, occlusal composite; 30 ...
5 excuse me, also 19B, if you see there on the
6 third column of the treatment plan, it has 19-0
7 and then 19-B, B for buccal, so that was also
8 another spot of decay on the buccal of that
9 tooth, on the outside.
- 10 Q: Okay. For the lay audience, what's the buccal?
- 11 A: A buccal is the cheek side of a back tooth.
- 12 Q: Okay.
- 13 A: On 30, the same thing, an occlusal and a
14 buccal, and 31 ... on 30, he had yet another
15 occlusal that popped up since then, and on 31,
16 he had an occlusal.
- 17 Q: Okay. Do you recall from memory what the level
18 of decay was on those ones that you called out?
19 And I can really just limit it to the ...
20 because the only ones that were substantively
21 sealed, I think, were 3, 14, 19 and 30, I
22 believe.
- 23 A: Uh-huh (affirmative response).
- 24 Q: Can you recall offhand or from memory what the
25 nature or the depth of the decay was on those

1 teeth?

2 A: Well, clinically speaking, you don't know the
3 depth of it, but using my explorer and
4 visualization, I immediately diagnosed all
5 those teeth as having decay. Using my
6 explorer, my sharp explorer with a light touch,
7 I got a stick, as Dr. Sneed said, just like
8 leather-like, put it in leather and it pulls
9 back and you get a little stick, on all those.
10 Also visualizing, especially number 3, number
11 3's the one that I definitely recall seeing a
12 dark halo on the occlusal surface from the
13 decay present.

14 Q: Okay. Now, you're aware, I guess, on 10/7 you
15 did your next, the patient showed up as
16 scheduled; is that correct?

17 A: That is correct.

18 Q: Okay. And it's in the record, in the meantime,
19 specifically on 9/18/03, certain procedures
20 were performed by the Respondent in this case,
21 Anonymous No. 2, which included prophylaxis,
22 fluoride, sealant for 3, 14, 19 and 30. And
23 that's on this document that you have in front
24 of you, and as you'll see, you saw evidence of
25 it.

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1 MS. BALLARD: Could we refer to the exhibit number,
2 please?

3 MR. WOODINGTON: It'd be nice if I had it.

4 MS. BALLARD: Exhibit Number Fourteen.

5 MR. WOODINGTON: Fourteen, okay.

6 Q: So the patient came back on 10/7/03, and what
7 did you observe at that point?

8 A: Well, for that appointment, I was to work on
9 ... I was to do occlusal composite restorations
10 on teeth number 2, 3, and 4, and a sealant on
11 number 5. And the first thing I always do
12 before administering any anesthetic is examine
13 the tooth again; number one, to get the tooth
14 right, and then also just to make sure that I,
15 I always want to double check. So I looked and
16 saw that a sealant was placed on number 3, the
17 occlusal surface of number 3. And then I
18 looked on the rest of the teeth and noticed
19 that sealants were placed as well on number 14,
20 19, and 30, which were not there on 9/2/03.

21 Q: Would you characterize the decay that you
22 observed on 9/2/03, how would you characterize
23 that decay in terms of frank or incipient or
24 somewhere in between?

25 A: It was frank. I would consider it frank

1 because just with my naked eyes I could see a
2 halo, an obvious halo, caused by decay on his
3 virgin teeth. There was no question in my
4 mind.

5 Q: And did you not propose to seal some of the
6 teeth?

7 A: That is correct. Due to his rampant caries
8 rate, I wanted to then protect or try to
9 protect the other teeth that we were not going
10 to be doing composite restorations on.

11 Q: Do you know ... can you recall whether there
12 was any incipient decay on any of the teeth you
13 proposed to seal?

14 A: There was not.

15 Q: Okay. In your opinion, should the decay you
16 observed on 9/2/03 have been apparent to the
17 hygienist who applied the sealants?

18 A: Yes.

19 Q: And again, is that based on the evidence you
20 just stated about the halo and so forth?

21 A: Yes, and using my eyes.

22 Q: Well, that's what I mean.

23 A: Yes, sir.

24 Q: Looking at ...

25 A: Yes, uh-huh.

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1 Q: Now, we have these photographs in here, I
2 guess, Number Thirteen, is that right?

3 COURT REPORTER: Yes, sir.

4 Q: And we've introduced these into evidence. I
5 don't know if you can look at these and tell
6 the panel anything more about this or not, but
7 go ahead and see what you can deduce from that.

8 A: Sure. Let me start off by saying that the
9 first intra-oral picture that I took was this
10 one which has the four pictures on it.

11 MS. BALLARD: We're referring to Exhibit Number
12 Thirteen for the record.

13 MR. WOODINGTON: Thirteen, the one with four pictures
14 on it.

15 A: Four pictures on it.

16 MR. WOODINGTON: These are all the same exhibit.

17 MS. BALLARD: They're all the same exhibit number,
18 correct.

19 A: I just took an intra-oral photo of the sealants
20 that were on there. Number 3, top left, is the
21 one that we were going to be working on that
22 day. So what I did at that point, I talked to
23 the mother and asked what had happened and she
24 said that he had sealants placed just a few
25 days prior. And I said, well, I'm going to

1 need to take the sealant off to get to the
2 decay that's underneath it. And she said,
3 okay. And I had her stand behind me in the
4 hallway observing what I was seeing. So the
5 next photo that I took was the one on the
6 bottom, it says number 3 after sealant removal
7 and fissurotomy.
8 Q: And for our lay audience that might eventually
9 review this, fissurotomy means?
10 A: Fissurotomy is just removing the enamel that's
11 in the grooves.
12 Q: Did that ... what ...
13 A: Gaining access to the decay.
14 Q: Okay. And what did that tell you with respect
15 to your prior conclusions about the extent of
16 decay on that tooth prior to sealing it?
17 A: That I was correct.
18 Q: Did you do that with any of the other teeth
19 that were on that ... 19, 14, and 30, did you
20 also ... I know you didn't take pictures.
21 A: No, I did not. I did not work on any other
22 tooth on that day. Well, on 2, 3, 4, and 5.
23 Q: Okay. I think you may have already answered
24 this, but what did you recommend to the parent
25 about tooth number 3?

- 1 A: That it ... as far as what I would need to do?
- 2 Q: What would be the ... what should be done for
- 3 tooth number 3 at this point? What did you
- 4 recommend?
- 5 A: That I should continue removing decay so that
- 6 the tooth would be decay free and then I would
- 7 place an appropriately sealed restoration in
- 8 there.
- 9 Q: Okay. Following this, and we only have the
- 10 chart that goes up through 10/7/03, did you
- 11 ever restore any of those other molars?
- 12 A: In regard to 14, 19, or 30?
- 13 Q: Correct...
- 14 A: No.
- 15 Q: Okay. You have not done that to this point?
- 16 A: That is correct.
- 17 Q: Has he been back to see you since 10/7/03?
- 18 A: No.
- 19 Q: Really?
- 20 A: He has not.
- 21 Q: Okay. Were you ever called or consulted by the
- 22 hygienist who placed the sealants on these
- 23 teeth?
- 24 A: No.
- 25 Q: Okay. Did you actually know yourself who

1 applied the sealants?

2 A: No.

3 Q: Did you have another appointment scheduled, did
4 you schedule another appointment after October
5 7, '03?

6 A: Yes.

7 Q: And he didn't show up after that?

8 A: That is correct.

9 Q: Have you ever declined to see this patient at
10 any time after this point?

11 A: No.

12 Q: One other thing, and this is painfully obvious
13 to everybody in the room except our lay
14 audience of judges that might read this one of
15 these days perhaps, can you describe what a
16 prophylaxis is?

17 A: A prophylaxis is ... another term for it is a
18 cleaning, cleaning the teeth.

19 Q: Did you do a prophylaxis on 9/2/03 or did your
20 hygienist ...

21 A: My hygienist did, yes, a child prophylaxis.

22 Q: I believe that's all I have for you.

23 DR. ADAMS - CROSS EXAMINATION BY MS. BALLARD:

24 Q: Just briefly, Dr. Adams, are you familiar with
25 the school-based dental hygienist program?

- 1 A: I am now.
- 2 Q: You were not previously?
- 3 A: Well, I knew that there was something going on
4 but I am not ... I didn't know any details. I
5 know more now than I did before.
- 6 Q: We all do, Dr. Adams.
- 7 A: Yeah.
- 8 Q: You indicated that on 3/4/03, you did an
9 occlusal on tooth number 30, correct?
- 10 A: That is correct.
- 11 Q: Now, on 9/2/03, when you proposed a treatment
12 plan, you proposed another occlusal on tooth
13 number 30?
- 14 A: That is correct.
- 15 Q: Why is that?
- 16 A: Because when you deal with occlusal composites
17 or an occlusal restoration or decay on any
18 posterior tooth, you have a lot of room and
19 there are a lot of different areas of the
20 occlusal surface in which decay can begin. So
21 just say the decay starts on the back side, on
22 one side of the occlusal, in one of the
23 grooves, on one end of the grooves.
- 24 Q: So are you saying this was on another location
25 on the same tooth?

1 A: Another location on the occlusal surface of the
2 tooth.
3 Q: Okay. So you weren't redoing one you'd already
4 done?
5 A: No, no.
6 Q: All right. Now, you instructed that this
7 patient come back to see you to have this work
8 completed after 10/7/03, correct?
9 A: That is correct.
10 Q: And he did not come back to see you, correct?
11 A: Correct.
12 Q: So as far as we know, he still has the benefit
13 of the sealants that were placed on his teeth
14 by Anonymous No. 2 on tooth 3 ... excuse me,
15 14, 19, and 30, correct?
16 A: I'm not aware that the sealants are still on
17 there.
18 Q: As far as we know, they're still on there,
19 correct? You didn't take them off, did you?
20 A: I did not take them off.
21 Q: Okay. And you've not seen this patient since
22 then, correct?
23 A: That is correct.
24 Q: All right. In the public school setting, in
25 the public health setting, you're aware, are

1 you not, that it's a practice, at least in some
2 locations, for sealants to be placed on teeth
3 that have either incipient or greater degrees
4 of caries because of the concern that students
5 might not see dentists again in the future,
6 correct?

7 A: Yes, I am now.

8 Q: And you're familiar with the fact that a
9 properly placed sealant can in fact arrest the
10 development of caries in a tooth if it's
11 properly placed and if the child doesn't see a
12 dentist after that, then we've accomplished
13 some preventive dentistry for that student,
14 correct?

15 A: According to Dr. Simonsen, yes.

16 Q: You disagree with Dr. Simonsen?

17 A: I don't have an opinion on that.

18 Q: That's fine. Thank you. What damage was
19 caused to Q.G., Q.G., as a result of having
20 sealant placed on tooth number 3 when he was
21 seen by Anonymous No. 2?

22 A: In the 19 days that the sealant was on his
23 tooth, I would ascertain in my opinion that
24 there was no damage.

25 Q: And it's not a painful process to remove the

1 sealant, is it?

2 A: No.

3 Q: It's not invasive in any way?

4 A: No.

5 Q: So if in fact when Anonymous No. 2 saw this ...
6 go ahead.

7 A: Let me interject with just one thing.

8 Q: Okay.

9 A: Unless, and I know some dentists do this, and
10 it can be recommended that a minimally invasive
11 procedure such as the air abrasion, I believe
12 we saw some pictures of that.

13 Q: Correct.

14 A: That is not always 100 percent pain free.
15 Therefore, if that is placed, then the patient
16 may feel that and then a sealant is placed,
17 and to remove that either with the air abrasion
18 unit or a dental hand piece, it could be
19 painful.

20 Q: Was there any pain for Q.G. in the removal of
21 the sealant on tooth number 3?

22 A: There was not, because I used anesthetic.

23 Q: Correct. And you would have done that whether
24 you were removing sealant or simply placing a
25 restoration, correct?

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- 1 A: If I were going to be removing a sealant that
2 was not prepared like we had just discussed a
3 minute ago ...
- 4 Q: Correct.
- 5 A: ... I would not have used anesthetic to remove
6 it.
- 7 Q: But if you're placing a restoration, you're
8 going to have provided anesthesia, correct?
- 9 A: Correct.
- 10 Q: So if you are removing a sealant for purposes
11 of placing a restoration, that child is going
12 to have anesthesia at the time that the sealant
13 is removed, correct?
- 14 A: That is correct.
- 15 Q: And there's not going to be any pain for him
16 other than the pain he would have had in
17 connection with the shot and the restoration,
18 correct?
- 19 A: He wouldn't have any pain for the shot for me.
20 But, yes, that is correct.
- 21 Q: Got you.
- 22 A: At least I do my best.
- 23 Q: Okay. And you don't have an opinion as to
24 whether the placement of sealant on incipient
25 or other kinds of caries in fact seals off the

1 nutrients and stops growth of the caries,
2 correct? You don't have an opinion on that?
3 A: I have a hard time believing it, but yet I know
4 there are studies on both sides.
5 Q: On both sides?
6 A: Well, that we've seen today that say one thing
7 or the other as far as it will arrest it and it
8 won't arrest it. So in regard to that, I will
9 make my judgment call with each individual
10 patient, each tooth that I see in which I think
11 is going to benefit the patient the best.
12 Q: In your practice, does it ever happen other
13 than in Q.G.'s case where you recommend
14 additional treatment and the patient doesn't
15 show back up?
16 A: It happens, yes.
17 Q: It happens?
18 A: Yes.
19 Q: And so if you had made the decision to place a
20 sealant on a tooth that you later planned to
21 restore and the patient didn't come back, would
22 you have accomplished something positive for
23 that patient by placing a sealant on the tooth?
24 A: I'm going to have to ask you please to repeat
25 that.

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1 Q: Sure. If in fact you had placed a sealant on
2 a tooth that had caries and planning to do a
3 restoration in the future, but that child did
4 not come back for the planned restoration, you
5 would in fact have accomplished something
6 positive for that child by placing a sealant on
7 a tooth with caries, correct?

8 A: Yes, but I would not have done that.

9 Q: My question was if you had?

10 A: And my first answer was yes.

11 Q: Thank you. That's all I've got, thank you.

12 DR. ADAMS - RE-DIRECT EXAMINATION BY MR. WOODINGTON:

13 Q: Following up on that last question for just a
14 minute, on a tooth with caries, this is a
15 fairly broad question, would you make a
16 distinction in your answer depending on whether
17 the carious growth was gross or incipient or
18 medium or somewhere in between?

19 A: Yes. I mean in my practice, if the caries
20 again was like what I diagnosed on Q.G., that
21 I could see it, that it was visible, I would
22 not have placed a sealant first. I would go
23 straight to the restoration.

24 Q: Do you think there would have been any benefit
25 from sealing that particular caries, that

1 particular tooth that you saw?

2 A: No.

3 Q: That's all I have.

4 CHAIRMAN RAWLS: Any questions from the panel?

5 DR. COOMBS: I have a question. Dr. Adams, according
6 to your records, you placed an occlusal
7 composite on tooth number 30 on March of '03.
8 Then when you examined the patient on October
9 7th, '03, you state, according to your records,
10 sealants replaced on 3, 14, 19, and 30. Where
11 was the sealant placed on number 30?

12 A: According to the picture, do you have the
13 pictures over there?

14 DR. COOMBS: I do.

15 MS. BALLARD: Exhibit Number Thirteen for the record.

16 A: You can see it right there.

17 DR. COOMBS: My question specifically is, was the
18 sealant placed over your restoration or was the
19 restoration only, and I imagine that's the
20 mesial pit of the tooth that does not have a
21 sealant on it?

22 A: That is correct.

23 DR. COOMBS: What is correct -- the sealant was
24 placed over the restoration or ...

25 A: That is correct.

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1 DR. COOMBS: Okay.

2 CHAIRMAN RAWLS: Any other questions? If not, Dr.
3 Adams, you're dismissed.

4 MS. BALLARD: Oh, I do have one follow-up, I'm sorry.

5 CHAIRMAN RAWLS: Okay.

6 DR. ADAMS - RE-CROSS EXAMINATION BY MS. BALLARD:

7 Q: I'm just curious. Let's look at your record,
8 if we would, Exhibit Number Twelve.

9 A: Sure.

10 Q: On 3/4/03 when you placed a partial occlusal on
11 number 30, did you seal the remainder of that
12 tooth?

13 A: No, I did not.

14 Q: Why not?

15 A: Because it did not have any decay present. The
16 grooves were fine and I just ... I went right
17 down to the ... into the cavity preparation and
18 closed that up.

19 Q: Okay. That's all I have.

20 MR. WOODINGTON: I have nothing else. At this point,
21 if I may make a statement. Dr. Adams has
22 testified that he saw frank cavitation, I
23 guess, if I'm using the right vocabulary. Dr.
24 Sneed, whose testimony we incorporate by
25 reference, has testified that placing sealants

1 over frank cavitation is a violation of the
2 standard of care. And based on that, on those
3 two ... putting two and two together, we're not
4 going to call Dr. Sneed to reiterate that, but
5 we rest our case based on those two ... on the
6 testimony in the courtroom and by reference
7 testimony.

8 MS. BALLARD: And I just, for the record as well, I
9 need to ensure that my question about the
10 existence of the complaint, whether he was
11 complaining or not, has been preserved. I
12 didn't specifically question him about that
13 because we indicated earlier that that issue
14 had been preserved, so I didn't even ask him
15 about that.

16 MR. ROSEN: We understand that that's preserved in
17 all of these cases.

18 MS. BALLARD: Thank you. Thank you. I just need to
19 make sure that was clear. I apologize for the
20 lawyer mumbo-jumbo.

21 CHAIRMAN RAWLS: Dr. Adams, you're dismissed.

22 MS. BALLARD: That would end your presentation?

23 MR. WOODINGTON: That's it.

24 MS. BALLARD: All right. We would call Dr. Simonsen.

25 COURT REPORTER: Just to remind you, Dr. Simonsen,

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1 you're still under oath.

2 DR. SIMONSEN: Yes.

3 DR. SIMONSEN - DIRECT EXAMINATION BY MS. BALLARD:

4 Q: Dr. Simonsen, look with me if you would, on
5 Exhibit Number Thirteen, which is ... these are
6 Exhibit Number Thirteen. Have you had an
7 opportunity to review those photographs?

8 A: Yes, I have.

9 Q: Even with the sealants in place, are you able
10 to offer an opinion as to whether or not there
11 was gross caries present at the time those
12 sealants were placed?

13 A: In my opinion, it's not gross caries.

14 Q: How would you describe the caries that the
15 sealants were placed on?

16 A: Incipient caries.

17 Q: Okay. And we know from your previous testimony
18 that placement of sealant on incipient caries
19 is certainly within the standard of care,
20 correct?

21 A: Yes.

22 Q: So do you have an opinion, to a reasonable
23 degree of certainty, as to whether Anonymous
24 No. 2 complied with the standard of care in
25 placing sealants on those four teeth when she

1 saw Q.G.?

2 A: Yes, I do.

3 Q: And what is your opinion?

4 A: That she complied with the standard of care
5 that would be for a child in a public health
6 program.

7 Q: That's all I've got. Thank you.

8 MR. WOODINGTON: I would just allow my cross-
9 examination of him in the previous case. I
10 think we can incorporate that by reference
11 also, I assume.

12 CHAIRMAN RAWLS: Yes.

13 MS. BALLARD: No objection. You may step down.

14 DR. COOMBS: I have a question.

15 MS. BALLARD: Oh, I'm sorry.

16 DR. COOMBS: Specific to this case, Dr. Simonsen, is
17 there any benefit to placing a sealant over a
18 composite restoration?

19 A: Yes. Well ...

20 DR. COOMBS: There's evidence to that?

21 A: In this specific case, I would have placed
22 what's called a preventive resin restoration,
23 placed the composite restoration and seal the
24 remaining pits and fissures so you don't have
25 to go back in and do another restoration in six

1 months' time.

2 DR. COOMBS: As to placing a sealant directly over a
3 previously restored tooth with no evidence of
4 decay around the restoration, is there any
5 factual basis to placing a sealant over top of
6 a composite restoration?

7 A: Well, if you remember with the days of G.B.
8 Black, we did what's called extension for
9 prevention and took out adjacent pits and
10 fissures. The object of putting a composite,
11 which conserves that tooth structure, you're
12 not doing extension for prevention, but you are
13 obliged to do the restoration and then use a
14 sealant to prevent having to do another
15 restoration in six months' time.

16 DR. COOMBS: I have no problem with you stating that
17 sealants placed in grooves of previously ... of
18 untreated areas. My specific question, is
19 there any need to place a sealant over a
20 restored area? That specific restored area of
21 the tooth?

22 A: No, there isn't. There's no ...

23 DR. COOMBS: Thank you.

24 A: It's very difficult not to do it.

25 DR. COOMBS: Okay.

1 MS. BALLARD: Any further questions?

2 CHAIRMAN RAWLS: Any questions? (No response.)

3 MS. BALLARD: Thank you, Dr. Simonsen.

4 A: Thank you.

5 MS. BALLARD: We would call Anonymous No. 2.

6 ANONYMOUS NO. 2, R.D.H., being duly sworn, testifies
7 as follows:

8 ANONYMOUS NO. 2 - DIRECT EXAMINATION BY MS. BALLARD:

9 Q: Anonymous No. 2, would you identify yourself
10 for the panel, please?

11 A: I am Anonymous No. 2.

12 Q: You were formerly known as Anonymous No. 2?

13 A: Yes. I was married in August.

14 Q: What is your ... where do you live?

15 A: I live in Woodruff, South Carolina.

16 Q: And approximately how long have you lived in
17 that area?

18 A: I've lived there 41 years. I'm 41.

19 Q: Okay. What's your educational background?

20 A: I was a dental assistant from 1988 ...

21 Q: Give me your ... okay, I'm sorry, go ahead.

22 A: I'm sorry. 1988 to 1992.

23 Q: Who did you work for?

24 A: Dr. Harold Colburn.

25 Q: In Spartanburg?

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- 1 A: Yes.
- 2 Q: Okay. And after that, what did you do?
- 3 A: I went to Greenville Tech, graduated in 1995
- 4 with a dental hygiene degree. Worked for
- 5 Marvin Anderson from '95 to '96.
- 6 Q: In what capacity?
- 7 A: Dental hygiene. I worked from '96 to 2003 with
- 8 B.J. ... I mean, B.H. Satterfield, I'm sorry,
- 9 in Spartanburg.
- 10 Q: Was your employment with Dr. Anderson and Dr.
- 11 Satterfield in the context of private practice?
- 12 A: Yes.
- 13 Q: And when did you come to work with HPS?
- 14 A: 2003, August of 2003.
- 15 Q: And you've been with them ever since?
- 16 A: Yes.
- 17 Q: Why did you leave the private practice and come
- 18 into the public school setting?
- 19 A: Well, we have another employee that I've known
- 20 all my life and she told me about all the
- 21 benefits and, you know, you do have a little
- 22 flexibility, you know, with schedules. And
- 23 like Anonymous No. 1 said, you can take all the
- 24 time you want with one child, and there is a
- 25 lot of rewards. And in private practice you

1 kind of get into the same humdrum experience,
2 so I thought this would be very beneficial to
3 help children.

4 Q: Now, when you first came to work with HPS, did
5 you have much background in the area of dental
6 sealants?

7 A: No.

8 Q: And what kind of education have you received
9 during your employment with HPS as to the use
10 of dental sealants?

11 A: Okay. We have seminars on dental sealants. We
12 have experts, you know, come in and give
13 seminars. I get ADHA journals, and also my
14 employer provides us with journals or papers on
15 sealants, dental sealants.

16 Q: What opinion have you developed regarding the
17 use of dental sealants in the public school
18 setting?

19 A: Say it one more time.

20 Q: What opinions, if any, have you drawn as to the
21 propriety of using sealants in the public
22 school setting?

23 A: I feel like it's very beneficial for most of
24 these kids because they do not have the
25 transportation or the parents who will take

1 them to the dentist.

2 Q: Is it fairly typical for you to see people who

3 have never seen a dentist before?

4 A: Oh, yes.

5 Q: And what kinds of services do you provide for

6 them when you see a student for the first time?

7 A: Okay. I do an examination, visual examination.

8 I scale their teeth, I polish, I floss, I place

9 fluoride, and if there is a need for sealants,

10 I will place sealants.

11 Q: And how do you make a determination as to

12 whether there is a need for sealants?

13 A: Say it one more time, I'm sorry.

14 Q: How do you make a determination as to whether

15 there is a need for sealants?

16 A: Well, I feel all kids need sealants. And I

17 check the tooth visually, see no gross decay,

18 I'll seal the tooth.

19 Q: Are you familiar with literature that indicates

20 that it's not only permitted but preferred to

21 place dental sealants over incipient caries in

22 the public school setting?

23 A: Yes.

24 Q: And is that a practice that you have employed

25 while working in the public school setting?

- 1 A: Yes.
- 2 Q: Let's look, if we could, at Exhibit Number
- 3 Fourteen, which is your record here.
- 4 A: Uh-huh (affirmative response).
- 5 Q: What is the front page of Number Fourteen?
- 6 A: This is his medical treatment plan that we send
- 7 home with each child, and if I get the paper
- 8 back with all the information signed by the
- 9 parent, I will see this child and do a cleaning
- 10 on this child.
- 11 Q: So before you saw Q.G., you had parental
- 12 permission to do so?
- 13 A: Yes.
- 14 Q: And you reviewed this medical history that was
- 15 provided to you?
- 16 A: Yes.
- 17 Q: Okay. Look, if you would, with me on the next
- 18 page. What day did you see Q.G.?
- 19 A: September the 18th of 2003.
- 20 Q: And what did you do at that time?
- 21 A: I reviewed his medical history, I did a prophylaxis,
- 22 placed fluoride, I did sealants on tooth number
- 23 3, 14, 19, 30. He had no initial complaints.
- 24 I did oral hygiene instructions and I coded him
- 25 a 10, which visually I saw no cavities.

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- 1 Q: Did you send home a letter with him?
- 2 A: Yes.
- 3 Q: What was the nature of that letter?
- 4 A: I would have checked that I cleaned his teeth,
- 5 that I placed fluoride, I placed sealants, and
- 6 that he had no obvious problems.
- 7 Q: Did you provide information so that you could
- 8 be contacted by either the current or treating
- 9 dentist?
- 10 A: Yes, I put my cell phone number.
- 11 Q: Your cell phone number?
- 12 A: Yes.
- 13 Q: Okay. That's all I have. Thank you.
- 14 MR. WOODINGTON: I have one or two questions, Mr.
- 15 Chairman.
- 16 ANONYMOUS NO.2 - CROSS EXAMINATION BY MR. WOODINGTON:
- 17 Q: Did I hear you testify, you said you think all
- 18 kids need sealants?
- 19 A: Yes.
- 20 Q: Okay.
- 21 A: Well, I should say all kids that don't have
- 22 gross decay, I'm sorry.
- 23 Q: Okay. Do you understand that it's part of your
- 24 responsibility to be able to spot gross decay?
- 25 A: Right.

1 Q: That's all I have.

2 CHAIRMAN RAWLS: Any members of the panel have any
3 questions?

4 DR. COOMBS: Can you clarify? You said code 10 means
5 what?

6 A: That the child has no obvious problems.

7 DR. COOMBS: Okay.

8 CHAIRMAN RAWLS: Also, on the Promotion Specialists
9 Consent for Services Form it mentions the
10 child's dentist, Dr. Adams. I thought it was
11 policy that if they have a dentist of record
12 that you didn't treat those patients; is that
13 true or not true?

14 A: Well, we leave it up to the parents. If the
15 parents want the treatment, then we're there
16 for the students.

17 CHAIRMAN RAWLS: Any other questions? (No response.)

18 Anonymous No. 2, you're dismissed.

19 ANONYMOUS NO. 2: Thank you.

20 MS. BALLARD: I would call Linda Clements, please.

21 LINDA CLEMENZ, being duly sworn, testifies as
22 follows:

23 MS. CLEMENZ - DIRECT EXAMINATION BY MS. BALLARD:

24 Q: Linda, would you identify yourself for the
25 panel, please?

- 1 A: Linda Clemenz, I am co-owner and chief
2 operations officer for HPS.
- 3 Q: In your capacity as chief operations officer
4 for HPS, do you work with billing and insurance
5 companies regarding the services that are
6 rendered by HPS?
- 7 A: Every day.
- 8 Q: In connection with Q.G., did he have private
9 insurance or was he a Medicaid patient?
- 10 A: Q.G. had Kanawha Insurance.
- 11 Q: Kanawha Insurance?
- 12 A: Yes.
- 13 Q: In your experience, have you determined whether
14 in the past Kanawha Insurance will pay for a
15 sealant on a tooth that has a previous
16 restoration?
- 17 A: Absolutely not.
- 18 Q: They will not pay?
- 19 A: They will not pay.
- 20 Q: And were you all paid for the placing of the
21 sealant on tooth number ...
- 22 A: Yes, we were.
- 23 Q: Let me finish the question. Were you all paid
24 for placing sealant on tooth number 30 for
25 Q.G.?

1 A: Yes, we were.

2 Q: That's all I've got. Thank you.

3 MR. WOODINGTON: No questions.

4 CHAIRMAN RAWLS: Any questions from the panel?

5 DR. COOMBS: I have a question. How does your

6 company make a determination whether you charge

7 an adult prophy versus a child prophy?

8 A: Based on age.

9 DR. COOMBS: And that age is what?

10 A: Twelve.

11 DR. COOMBS: Age 12, they're defined as an adult?

12 A: Per Medicaid guidelines.

13 DR. COOMBS: Okay. Thank you.

14 MS. BALLARD: We have nothing further.

15 MR. WOODINGTON: Nothing on reply.

16 CHAIRMAN RAWLS: Are we going to hear closing

17 arguments?

18 MS. BALLARD: We were going to defer those until the

19 end of the case.

20 MR. ROSEN: I was just wondering if it might not be

21 beneficial that we have closing and that they

22 entertain the possibility of deliberations on

23 these two, if that would be of any value?

24 MS. BALLARD: No, we would prefer, and frankly based

25 on our discussion earlier, I didn't prepare my

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1 closing because I thought we were going to do
2 that tomorrow.

3 CHAIRMAN RAWLS: Okay. That's all ...

4 MR. ROSEN: Is that all right with you?

5 MR. WOODINGTON: That's fine.

6 CHAIRMAN RAWLS: Okay. That being the case, we're
7 finished for today.

8 MS. BALLARD: The record is still open by the way in
9 the first case for that additional document, so
10 we couldn't deliberate yet anyway. Y'all
11 couldn't deliberate.

12 (There being no further matters, the hearing was
13 adjourned at 6:40 p.m.)
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CERTIFICATE

This is to certify that the within panel hearing consisting of Forty (40) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said panel hearing was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on September 11, 2006.



Robin K. Reibold
Court Reporter

Notary Public for South Carolina
My Commission Expires: May 11, 2011

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SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING & REGULATION
BEFORE THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

In the Matter of:) REVISED TRANSCRIPT
ANONYMOUS NO. 3, R.D.H.) WITH REDACTED NAMES
License No. 1064) PURSUANT TO ORDER OF
Respondent.) CAROLYN C. MATTHEWS,
-----) ADMINISTRATIVE LAW
) JUDGE, DATED
) AUGUST 2, 2006
) (Order attached)

COPY

PANEL HEARING

Saturday, December 3, 2005
9:42 a.m. - 12:02 p.m.

The Panel Hearing before the South Carolina State Board of Dentistry was held at the Synergy Office Park, Kingstree Building, Room 113, 110 Centerview Drive, Columbia, South Carolina, on the 3rd day of December, 2005 before Robin K. Reibold, Court Reporter and Notary Public in and for the State of South Carolina.

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(F.B. Chart - Dr. Ackerman)	
Petitioner's Exhibit Number Nineteen	4
(F.B. Records - HPS)	
Petitioner's Exhibit Number Twenty	4
(F.B. - X-rays)	
Petitioner's Exhibit Number Twenty-one	4
(B.W. Chart - Dr. Padgett)	
Petitioner's Exhibit Number Twenty-two	4
(B.W. Records - HPS)	
Petitioner's Exhibit Number Twenty-three	4
(B.W. - X-rays)	
Respondents' Exhibit Number Twelve	8
(Youmans Ltr to Senator Drummond)	
Respondents' Exhibit Number Thirteen	22
(Ackerman ADA Letter)	
Respondents' Exhibit Number Fourteen	27
(M.H. Records)	
Respondents' Exhibit Number Fifteen	92
(Handout - Sealants)	
Respondents' Exhibit Number Sixteen	108
(Tooth Decay Booklet)	

STIPULATIONS

Upon stipulation and agreement by all parties, Petitioner's Exhibit Numbers One through Seventeen and Respondents' Exhibit Numbers One through Eleven, Seventeen and Eighteen are to be incorporated into this hearing.

It is further stipulated and agreed that this hearing is being taken pursuant to the Administrative Procedures Act, the Practice Act and Regulations of the Board.

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1 (Petitioner's Exhibit Numbers Eighteen through
2 Twenty-three were marked and entered into the record
3 prior to the hearing by stipulation and agreement by
4 both parties.)

5 CHAIRMAN RAWLS: This is a hearing in the matter of
6 Anonymous No. 3, RDH, being held in Columbia,
7 South Carolina this 3rd day of December 2005.
8 My name is Dr. Douglas Rawls. I'm chairman of
9 this hearing. The other members of the panel
10 hearing this case are Dr. Ben Jett, Dr. Paul
11 Coombs, Dr. Charles Wade, and Ms. Debra Baker,
12 RDH. Representing the Board is Mr. Louis Rosen
13 to my left. Respondent is represented by Ms.
14 Desa Ballard and also Mr. Creighton Coleman.
15 The State is represented by Mr. Ken Woodington.
16 This hearing will be conducted as informally as
17 possible, as is compatible with the equitable
18 presentation of both sides of the case, and is
19 in compliance with the provisions and the
20 Administrative Procedures Act, the Practice
21 Act, the Regulations of the Board. The State
22 and the Respondent may, if they so desire, make
23 opening statements. Thereafter, the State
24 shall present its case and then the Respondent
25 will present her case. Both parties may make

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1 closing statements if they wish. The State
2 will have the option of a closing statement in
3 reply. Are there any issues today, prior to
4 the beginning of the first hearing?

5 MS. BALLARD: I have one additional exhibit that I
6 provided to Mr. Woodington and to Mr. Rosen
7 that I would like to introduce pursuant to Rule
8 803 Subsection 4 and Subsection 8 of the Rules
9 of Evidence. It is a letter from Adrienne
10 Youmans, the Director of LLR to Senator
11 Drummond discussing, in response to some
12 inquiries from Senator Drummond, that there are
13 two different standards of care for the
14 practice of dental hygienists; one in the
15 schools and one in the private practice
16 setting. We believe this is admissible in the
17 overall cases which are being incorporated into
18 all four cases and most of that evidence was
19 put in number one, so I would like to
20 technically offer this exhibit as to number one
21 so that's it applicable to all four of the
22 cases. I provided a copy to Mr. Woodington.

23 MR. WOODINGTON: My response to that, Mr. Chairman, I
24 would normally object because Ms. Youmans of
25 course was in the building presumably yesterday

1 and she's not today and I can't ask her what
2 she meant when she said this, but the reason I
3 am not going to object ... well, I think it's
4 irrelevant. And the reason it's irrelevant I
5 believe is, if you look at the bottom sentence
6 on the first page. I think you all have copies
7 of it?

8 CHAIRMAN RAWLS: No.

9 MS. BALLARD: No, I haven't given it to them until it
10 was admitted.

11 MR. WOODINGTON: Okay. I have no objection to your
12 passing it out.

13 MS. BALLARD: This is Respondent's Exhibit Number
14 Twelve.

15 MR. WOODINGTON: To state more precisely where I am
16 on it, I believe it's irrelevant, but don't
17 object to it because it's so irrelevant the
18 Panel can consider it for what it's worth and
19 it shouldn't affect the outcome of the
20 proceeding, and I'll tell you why. If you look
21 at the last two sentences at the bottom of the
22 first page, it says, the General Assembly set
23 two different standards for the two types of
24 practice settings, which sounds nice, but when
25 you look up a little further, the two different

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1 standards they're talking about are whether the
2 dentist needs to be there, the supervising
3 dentist needs to be there or not. And that's
4 the only issue that that letter addresses. And
5 when it talks about two different standards,
6 it's talking about the presence or absence of
7 the supervising dentist. So it's my position
8 that it's irrelevant, but it's a public
9 document and if the panel wishes to consider it
10 for what it's worth, that's fine.

11 MS. BALLARD: For purposes of the record, the reason
12 we didn't bring it up yesterday is I was
13 unaware of it. We just received it this
14 morning. And it's clearly relevant because the
15 legislature has determined what general
16 supervision means, and therefore, in construing
17 what general supervision means in the two
18 contexts it has by definition, according to Ms.
19 Youmans, established two standards of care for
20 dental hygienists; one in the school setting
21 and one in private practice, which is
22 consistent with the level of liability assumed
23 by the dentist, the supervising dentist. So
24 that will be introduced as Exhibit Number
25 Twelve for the Respondent, and applicable to

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1 all cases.

2 (Respondents' Exhibit Number Twelve was entered into
3 evidence.)

4 CHAIRMAN RAWLS: Any other issues?

5 MR. WOODINGTON: I think now we're ready to proceed
6 with the two cases of Anonymous No. 3, if I
7 may. These are two cases; one is a formal
8 accusation with two numbers on it, 0298 and
9 0299, the other one does not ... it's dated, I
10 think, September 13th, 2004. It doesn't have a
11 number on it. They're both Anonymous No. 3
12 (sic) who I understand is now Anonymous No. 3.
13 On the one with the number 0298 and 0299, if
14 you look at that formal accusation you will see
15 paragraphs one thru six. Pursuant to the
16 authority that I believe I have in this
17 capacity, I am withdrawing the allegations of
18 paragraph one thru three which apply to a
19 patient named M.H. We plan to go forward with
20 the allegations in paragraph four thru six
21 relating to somebody named F.B. and also the
22 allegations in paragraph one, the other formal
23 accusation, which relate a patient called BW,
24 which would be B.W. That's what I intend to do
25 with those cases and just wanted to let the

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1 Board panel know up front that that's where we
2 are.

3 MS. BALLARD: We have no objection to the withdrawing
4 of the allegations as to M.H., but we reserve
5 our right to cross-examine the treating dentist
6 on that particular patient.

7 MR. WOODINGTON: That's fine.

8 CHAIRMAN RAWLS: That's fine.

9 MR. WOODINGTON: With that, I'm ready to proceed and
10 call the witness, the first witness. We have
11 two dentists, two examining dentists in this
12 one Anonymous No. 3 case, with two different
13 patients. The first one will be Dr. Gray
14 Ackerman.

15 WILLIAM G. ACKERMAN, D.M.D., being duly sworn,
16 testifies as follows:

17 MR. WOODINGTON: As I get ready to do this, I'm going
18 to hand up to the Chair or Mr. Rosen, whoever
19 wants it, a numbered list of exhibits for today
20 and we will actually start with Exhibits
21 Eighteen, Nineteen, and Twenty, will be the
22 ones that are pertinent to this.

23 MS. BALLARD: Which one is Eighteen?

24 MR. WOODINGTON: Eighteen is the Ackerman chart for
25 F.B..

1 MS. BALLARD: Nineteen is HPS records for F.B., and
2 Twenty, which there is just one copy of except
3 for Desa has one, x-rays and Panorex for this
4 patient which I will pass around when the time
5 comes.

6 MS. BALLARD: Thank you.

7 MR. WOODINGTON: And I guess I'm going to ask the
8 witness ...

9 DR. ACKERMAN - DIRECT EXAMINATION BY MR. WOODINGTON:

10 Q: All right. Dr. Ackerman, can you state your
11 full name for the record, please?

12 A: Dr. William Gray Ackerman.

13 Q: Okay. And you're a practicing dentist?

14 A: Yes.

15 Q: And where do you practice?

16 A: Greenwood, South Carolina.

17 Q: What's your educational background?

18 A: Clemson, BS degree; Medical University of South
19 Carolina, Doctorate of Dental Medicine,
20 graduated in 1976.

21 Q: Okay. Have you been practicing ever since
22 1976?

23 A: Yes, I have.

24 Q: Where have you been practicing?

25 A: Greenwood, South Carolina.

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1 Q: Have you been in your own practice all that
2 time?

3 A: Yes, I have.

4 Q: So that's almost thirty years?

5 A: Yes.

6 Q: Are you here under subpoena?

7 A: Yes.

8 MR. WOODINGTON: Without further ado, we would offer
9 Dr. Ackerman in the usual fashion as an expert
10 in general dentistry, including the diagnosis
11 and treatment of tooth decay.

12 MS. BALLARD: No objection.

13 CHAIRMAN RAWLS: We'll accept him as an expert.

14 MR. WOODINGTON: To try to make this go a little
15 smoother, Mr. Chairman, if you'll look at
16 Exhibit Nineteen, which is the HPS records for
17 the patient named F.B., I'll just go over this
18 so we'll have some background and speed it up.
19 You'll see that there is a letter that says,
20 your child, F.B. was treated and seen by me on
21 11/8/02. That's the first letter. The second
22 letter says that ... and the sealants were
23 placed on permanent back teeth, that's the
24 first page of that. And then the second letter
25 from Anonymous No. 3 indicates some more

1 treatment on 11/12, although that's not
2 relevant to our purposes today. Now then, with
3 that, we'll proceed to the chart which is our
4 Exhibit Eighteen, Dr. Ackerman's chart.

5 Q: And Dr. Ackerman, I would ask you, was F.B. a
6 patient of yours at one time?

7 A: Yes.

8 Q: How old was he roughly, do you remember?

9 A: Roughly, I don't remember.

10 Q: Okay. Was he a child?

11 A: Yes.

12 Q: Okay. What does your ... you have your chart
13 there, can you just illuminate us a little
14 about what that shows?

15 A: He came into the office for, as a referral from
16 HPS and we did an exam and took some x-rays.

17 Q: And this is 11/18/02?

18 A: Yes, 11/18/02.

19 Q: Okay.

20 A: And at that time it was diagnosed that he had
21 decay up under some sealants that were placed,
22 as per the grandmother, at school and at that
23 time I showed the sealants to the grandmother
24 and the decay that was surrounding and up under
25 the sealants. And the sealants were removed

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- 1 and the teeth were properly restored.
- 2 Q: Okay. Let me show you the x-ray, which I think
- 3 is Exhibit Twenty. I'm not sure, but this is
- 4 the x-ray of young F.B.?
- 5 A: Yes.
- 6 Q: And what does that show by way of decay?
- 7 A: It shows ...
- 8 Q: Excuse me. Just on the permanent molars,
- 9 permanent back molars.
- 10 A: It shows occlusal decay up under the ...
- 11 penetrating the enamel slightly into the dentin
- 12 of the tooth.
- 13 Q: Which ones?
- 14 A: Number 14 and 19.
- 15 Q: Okay. How about number 3 and 30?
- 16 A: No.
- 17 Q: No decay on 3 and 30?
- 18 A: No, no decay.
- 19 MR. WOODINGTON: I'll just pass this around like
- 20 we've been doing.
- 21 Q: How would you describe the decay on 14 and 19?
- 22 A: It was obvious to the eye. I didn't really
- 23 need the x-rays, and that's why I showed it to
- 24 the grandmother just so she would be aware of
- 25 what was going on and why we were having to

1 take the sealants out at the place of the
2 decay. So it was pretty obvious. It was
3 obvious enough for me to show the mother or
4 grandmother, then it had to be pretty obvious.

5 Q: Was it obvious ... were the sealants still in
6 place when you say it was obvious?

7 A: Yes, they were still in place.

8 Q: Okay. And what precisely did you see, do you
9 recall?

10 A: Not precisely, but in general what we see is
11 the, around the edge of the sealants we'll see
12 decay.

13 Q: Okay. Would the word "halo" be an accurate
14 word?

15 A: Yes.

16 Q: What kind of halo was it?

17 A: It was dark.

18 Q: Did the decay extend, this again is just on 14
19 and 19, extend into the dentin?

20 A: Yes, it did.

21 Q: Okay. In your opinion, should ... I think you
22 already answered this, but should the decay you
23 observed on that date been apparent to the
24 hygienist?

25 A: It should have.

- 1 Q: Okay. What did you recommend to the parent?
- 2 A: I recommended that we remove the sealants and
- 3 place fillings.
- 4 Q: On 14 and 19?
- 5 A: Fourteen and 19.
- 6 Q: Did you in fact do that?
- 7 A: Yes, we did.
- 8 Q: Okay. Did you do anything with the other two,
- 9 3 and 30?
- 10 A: No.
- 11 Q: And why not?
- 12 A: The sealants on those teeth seemed fine.
- 13 Q: Okay. Did you know who applied the sealants at
- 14 the time?
- 15 A: No, not to my recollection, I can't tell you
- 16 for sure, no.
- 17 Q: That's shown by the evidence otherwise. Were
- 18 you ever ... did the hygienist who placed the
- 19 sealants ever call and consult with you?
- 20 A: No, I don't believe so.
- 21 Q: Okay. Have you done anything with this patient
- 22 since this one visit on 11/18/02?
- 23 A: No, I have not.
- 24 Q: Okay. Did you ever decline to see this patient
- 25 at any time before or after that?

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