BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA BOARD OF DENTISTRY, Petitioner,	:	Docket No.: OSAH-PLBD-DEN-1522089-5-Walker
v.	:	Agency Reference No. 1522089
ROY LEHRMAN, DDS, Respondent.	:	

INITIAL DECISION

The Georgia Board of Dentistry (hereinafter "Petitioner" or "Board") seeks revocation of Respondent Roy Lehrman's dental license. A hearing took place on February 4, 2015. Assistant Attorney General Bryon Thernes appeared for the Board. Respondent failed to appear at the hearing.[1] For the reasons stated below, the undersigned **AFFIRMS** Petitioner's proposed sanction finding that Respondent's dental license should be **REVOKED.**

[1] This matter was originally scheduled for January 6, 2015. Respondent moved to continue the matter, requesting additional time to prepare for the hearing. Respondent's motion was granted and the hearing date was continued to February 4, 2015. In the interim Respondent's attorney, Frances Cullen Esq., moved to withdraw from representation. Receiving no opposition from Respondent, the undersigned granted his attorney's motion to withdraw. On the date of the hearing, Mr. Thernes represented to the undersigned that on February 3, 2015, he had received a phone call from B. Panail. Mr. Panail stated that he was an attorney who would like to represent Respondent, but that he could only undertake representation if Petitioner would consent to a continuance in the case. Petitioner declined to consent to a continuance. On the date of the hearing, the undersigned's assistant received a telephone call purporting to be from Respondent's wife. She stated that Respondent was ill. While Respondent did not specifically request a continuance, the oral communication suggests that he again was requesting that the matter be continued. After the hearing commenced, Respondent submitted a receipt indicating that he paid Middle Georgia Ear Nose and Throat $85.00 for services on the date of the hearing. Respondent did not submit sufficient documentation indicating that he was unable to appear at the hearing for medical reasons and therefore a second continuance in this matter is **DENIED**.

FINDINGS OF FACT

1.

Respondent was first licensed to practice dentistry in the State of Georgia on or about June 9, 1980, and has been licensed to practice dentistry in the State of Georgia at all times relevant herein. Respondent was the subject of a previous disciplinary action resulting in a Public Consent Order on or about August 27, 1999. (Petitioner's Statement of Matters Asserted ¶ 1; Respondent's Answer ¶ 1; Testimony of Anil Foreman; Exhibit P-A).

2.

In the instant case, the Board appointed a peer reviewer to evaluate Respondent's treatment of seventeen of his patients. Respondent provided the patients' records to the Board. Following the peer reviewer's evaluation of these records, the Board filed a Statement of Matters Asserted alleging Respondent's care had failed to conform to the minimum standards of acceptable and prevailing dental practice.[2] Accordingly, the Board seeks revocation of Respondent's dental license. In response to the Statement of Matters Asserted, Respondent denies the allegations that he failed to conform to the minimum standard of acceptable and prevailing dental practice. (Petitioner's Statement of Matters Asserted; Respondent's Answer).

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[2] In the Statement of Matters Asserted, the Board also asserts Respondent made a material misrepresentation to the Board on his 2011 renewal application regarding his ability to practice dentistry with reasonable skill and safety. Specifically, Respondent made the following assertions in a 2011 lawsuit arising from injuries sustained at the Marriot Century Center in 2010: (1) "As a result of his injuries, Dr. Lehrman has had to endure two corrective surgeries upon his right thumb"; (2) "As a result of his injuries, Dr. Lehrman has been disabled and is unable to practice dentistry", and (3) "As a result of the injury to his thumb, Dr. Lehrman may never be able to practice dentistry again. . . ." The Board asserts that Respondent thus made a material misrepresentation to the Board by answering "No" to the following question on his 2011 renewal application: "Are you currently unable to practice under your license with reasonable skill and safety to the public by reason of . . . any mental or physical condition?" Petitioner filed an Initial Statement of Matters Asserted on November 17, 2014, and an Amendment to the Statement of Matters asserted on December 24, 2014. (Testimony of Anil Foreman; Exhibits P-B, P-C).

3.

Dr. Clyde Andrews is the Board's appointed peer reviewer in this case. He testified as an expert witness at the hearing. Dr. Andrews received a Bachelor's Degree in Chemistry from the University of Georgia, a Dental Degree from Emory University, and specialized endodontics training in root canal therapy from the Medical College of Virginia. He has been practicing endodontics since 1979. He was a member of the Georgia Board of Dentistry for ten years during which time he also served as president of the Board. (Testimony of Clyde Andrews).

4.

Dr. Andrews evaluated Respondent's treatment of and record keeping for seventeen of his patients. Respondent performed root canals on each of these patients. After reviewing patient records, Dr. Andrews found numerous gross violations of the generally accepted minimum standard of care of acceptable and prevailing dental practice. He also determined that Respondent's record keeping did not meet the minimum standard of care. (Testimony of Andrews).

5.

On or about May 5, 2013, Respondent provided care and treatment to patient C.M., including a root canal on tooth # 4, which fell below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient C.M. and found that the root canal performed shows extreme transportation and overfill, and an extreme access opening in the pulp chamber. There was not an adequate seal at the end of the root of the tooth, leaving an opening for bacteria to accumulate and a subsequent infection. Dr. Andrews noted that an x-ray

appears to show the patient had two canals, but only one of the canals was treated. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that C.M.'s dental record did not contain a pre-operative diagnosis. C.M.'s dental record does not contain any indication that C.M. was informed of the post-operative condition of tooth # 4. (Testimony of Andrews; Exhibit P-D1).

6.

On or about July 22, 2013, Respondent provided care and treatment to patient M.R., including root canals on teeth # 27 and # 28, which fell below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient M.R. and found that tooth # 27 was poorly obturated and the apical constriction was not maintained properly. Tooth # 28 was grossly over instrumented and overfilled, and also had a second canal that was not treated. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that M.R.'s dental record did not contain a pre-operative diagnosis. When a root canal is performed, a dentist should complete a pre-operative analysis of the patient's clinical symptoms or documented reason for a root canal. Respondent did not complete such documentation. M.R.'s dental record does not contain any indication that M.R. was informed of the post-operative condition of teeth # 27 and # 28. It is below the standard of care to fail to inform a patient of the post-operative condition of his or her tooth. (Testimony of Andrews; Exhibit P-D2).

7.

On or about July 25, 2013, Respondent provided care and treatment to patient T.D., including a root canal on tooth # 14, which fell below the minimum standards of acceptable and prevailing dental practice. Dr. Andrews evaluated Respondent's records, including x-rays, for patient T.D. and found that the root canal performed shows gross overfill of the palatal canal, as well as gross over-preparation of the coronal pulp space. Respondent also neglected to treat the patient's mesio-buccal canal. The gross overfill could easily have been corrected if Respondent had performed post-operative x-rays. (Testimony of Andrews; Exhibit P-D3).

8.

On or about August 5, 2013, Respondent provided care and treatment to patient W.B., including a root canal on tooth # 3. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that W.B.'s dental record did not include a pre-operative diagnosis that a root canal was necessary. From the x-ray available, Dr. Andrews determined that Respondent may have perforated the pulp floor on the mesial of palatal and/or disto-buccal root. (Testimony of Andrews; Exhibit P-D4).

9.

On or about September 3, 2013, Respondent provided care and treatment to patient B.L., including a root canal on tooth # 14, which fell below the minimum standards of acceptable and prevailing dental practice. Dr. Andrews evaluated Respondent's records for patient B.L. and found that root canal fill material was placed into jaw's boney space, rather than the mesio-buccal canal II as indicated by Respondent's records. This could

result in chronic infection. He also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that B.L.'s dental record did not contain a pre-operative diagnosis. B.L.'s dental record does not contain any indication that B.L. was informed of the post-operative condition of tooth # 14, although an x-ray in the records demonstrates the errors that had occurred during the procedure. The standard of care is that a patient should be so informed. (Testimony of Andrews; Exhibit P-D5).

10.

On or about November 4, 2013, Respondent provided care and treatment to patient R.F., including a root canal on tooth # 12, which fell below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient R.F. and found that the root canal was over instrumented at the apical constriction and the access for the canals was grossly over-prepared in the pulp chamber. Respondent "cut away" too much of the tooth, making it far more likely to break in the future. He also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that R.F.'s dental record did not contain a pre-operative diagnosis. An examination of the pre-operative x-ray does not indicate that a root canal was warranted. R.F.'s dental record does not contain any indication that B.L. was informed of the post-operative condition of tooth # 12. (Testimony of Andrews; Exhibit P-D6).

11.

Respondent treated patient L.H. on at least two occasions. On or about December 31, 2013, Respondent provided care and treatment to patient L.H., including a root canal

on tooth # 9, which fell below the minimum standards of acceptable and prevailing dental practice. On or about February 26, 2014, Respondent again provided care and treatment to patient L.H., including a root canal on tooth # 10, which fell below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient L.H. and found that tooth # 9 showed a perforation at the mesio-cervical canal, which appears to have been appropriately repaired; however, he found that tooth #10 remained grossly overfilled. He also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that L.H.'s dental record did not contain pre-operative diagnoses for these two teeth. L.H.'s dental record does not contain any indication that B.L. was informed of the perforation or the post-operative condition of tooth # 9. (Testimony of Andrews; Exhibit P-D7).

12.

On or about August 12, 2013, Respondent provided care and treatment to patient T.P., including a root canal on tooth # 19. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice. T.P.'s dental record did not include a pre-operative diagnosis or clinical findings that a root canal was warranted, and the post-operative x-ray of tooth # 19 was of inadequate diagnostic quality because of improper methodology. (Testimony of Andrews; Exhibit P-D8).

13.

On or about August 6, 2013, Respondent provided care and treatment to patient W. Y., including a root canal on tooth # 21, which fell well below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient W.Y. and found that of the three canals addressed by Respondent, one was obturated and over-filled, the second was sparsely filled and short, and the third canal was not treated. According to Dr. Andrews, this tooth now should be extracted because Respondent's improper treatment has dramatically increased the risk of infection, but W.Y.'s dental record does not contain any indication that the patient was informed of the post-operative condition of tooth # 21. He also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that W.Y.'s dental record did not contain pre-operative notes for tooth # 31 indicating that a root canal was warranted. (Testimony of Andrews; Exhibit P-D9).

14.

On or about November 12, 2013, Respondent provided care and treatment to patient L.J., including a root canal on tooth # 29, which fell below the minimum standards of acceptable and prevailing dental practice. The root canal performed on tooth # 29 was grossly overfilled in the pulp chamber. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice as to tooth # 29 in that L.J.'s dental record did not contain a pre-operative diagnosis and does not indicate why Respondent performed another root canal on the same tooth in January 2014. A review of the patient's file also indicated that or about October 30, 2008, Respondent provided care and treatment to patient L.J., including a root canal on tooth # 20 which fell

below the minimum standards of acceptable and prevailing dental practice in that L.J.'s dental record did not contain documentation that the pre-operative x-ray showed a possible fracture, and did not contain notes regarding any clinical examination of tooth # 20 to confirm or deny the fracture. Dr. Andrews asserted at the hearing that that this tooth should be extracted. (Testimony of Andrews; Exhibit P-D10).

15.

On or about August 13, 2013, Respondent provided care and treatment to patient M.M., including a root canal on tooth # 3, which fell below the minimum standards of acceptable and prevailing dental practice. There were no records indicating a root canal was warranted before it was performed. Respondent's records for patient M.M. indicates that the root canal performed on tooth # 3 shows a gross pulp floor perforation. It is likely that this patient will lose this tooth due to the gross pulp floor perforation. (Testimony of Andrews; Exhibit P-D11).

16.

On or about April 25, 2013, Respondent provided care and treatment to patient B.A., including a root canal on tooth # 27, which fell below the minimum standards of acceptable and prevailing dental practice. The root canal performed on tooth # 27 resulted in extreme overfill of one of the two canals treated. Both canals should have been treated. As a result of Respondent's care, the prognosis for the tooth is guarded. (Testimony of Andrews; Exhibit P-D12).

17.

On or about May 19, 2014, Respondent provided care and treatment to patient A.H., including a root canal on tooth # 18, which fell below the minimum standards of

acceptable and prevailing dental practice. Dr. Andrews noted that this root canal was probably "the worst I have ever seen." After evaluation by Dr. Andrews, Respondent's records demonstrate that the root canal performed was extremely compromised and the root canal was performed in the bone rather than the root structure. At the hearing Dr. Andrews stated that "I can't imagine how a coherent dentist would [perform this procedure]." Dr. Andrews also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that, although he believes that Respondent may have retreated tooth #18 four days after the initial procedure, any retreatment was inadequate. Moreover, the record does not contain an acceptable description of clinical findings or of the treatment provided. Further, the record does not contain any indication that A.H. was informed of the post-operative condition of tooth #18. There is a reasonable chance the tooth will have to be extracted due to the poor care provided by Respondent. (Testimony of Andrews, Exhibit P-D13).

18.

On or about May 15, 2014, Respondent provided care and treatment to patient L.R., including a root canal on tooth # 31, which fell below the minimum standards of acceptable and prevailing dental practice. The x-rays in the record do not indicate a need for a root canal. Respondent's progress notes do not contain an adequate account of patient symptoms to justify the performance of a root canal. Even if a root canal was appropriate, the x-rays reveal that Respondent drilled too far into the tooth and perforated an otherwise normal pulp floor and open, non-calcified, canals. Dr. Andrews also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that, although there is an

indication that Respondent may have attempted to remedy his mistakes at a later date, there was no indication that he charted the procedure adequately or that L.R. was informed of the tooth's post-operative condition. (Testimony of Andrews, Exhibit P-D14).

19.

On or about August 26, 2013, Respondent provided care and treatment to patient C.C., including root canal therapy on tooth # 16. On or about January 7, 2014, Respondent provided root canal therapy on C.C.'s tooth # 3. On or about April 21, 2014, Respondent provided root canal therapy on tooth # 19. All of this treatment fell below the minimum standards of acceptable and prevailing dental practice. Specifically, Dr. Andrews evaluated Respondent's records for patient C.C. and found that: as to tooth # 16 Respondent over-instrumented or overfilled the canals. As to tooth # 3, Respondent did not fill at least one of the canals, inserted gutta percha into the bone, and grossly violated the pulp floor such that tooth # 3 will likely have to be extracted. As to tooth # 19, Respondent failed to obtain a post-operative radiograph showing the apex of the root tips of tooth # 19. Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that, because there is no indication that C.C. was informed of the post-operative conditions for either tooth # 16, tooth # 19 or tooth # 3. In contrast, records reviewed by Dr. Andrews reflect that in 2001 Respondent also performed a root canal for patient C.C. but that this procedure was carried out well within the acceptable standard of care. (Testimony of Andrews, Exhibit P-D15).

20.

On or about January 15, 2014, Respondent provided care and treatment to patient C.H., including a root canal on tooth # 5, which fell below the minimum standards of acceptable and prevailing dental practice. Respondent failed to remove an infection in the tooth's root, perforated the tooth, placed the root canal filling material outside the root structure partially in bone, and inappropriately prepared a crown for tooth #5 on the same day. Dr. Andrews stated that it would be inappropriate to crown a tooth until a dentist can be sure that a root canal is successful. Dr. Andrews also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that C.H.'s dental record does not contain any indication that C.H. was informed of tooth #5's post-operative condition. (Testimony of Andrews; Exhibit P-D16).

21.

On or about January 13, 2014, Respondent provided care and treatment to patient L.M., including root canal therapy on tooth # 30, which fell below the minimum standards of acceptable and prevailing dental practice. Respondent committed a gross violation by obliterating/eliminating the pulp floor and furcation, the area below the pulp floor, during the root canal procedure. This gross violation is not reflected in the progress notes; further, the x-rays in the record are inconsistent with the progress notes. There is no reasonable assurance that the root canal was justified. Dr. Andrews also found that Respondent's record keeping fell below the minimum standards of acceptable and prevailing dental practice in that L.M's dental record does not contain any indication

that L.M. was informed of tooth # 30's post-operative condition. (Testimony of Andrews; Exhibit P-D17).

CONCLUSIONS OF LAW

1.

Sanction of the Respondent's license is sought pursuant to the following provisions of O.C.G.A. §§ 43-11-47, 43-1-19 and Rule 150-8-.01, as amended. O.C.G.A. § 43-11-47 provides that:

> (a) The board shall have the authority to refuse to grant a license to an applicant or to revoke the license of a dentist licensed by the board or to discipline a dentist licensed under this chapter or any antecedent law upon a finding by a majority of the entire board that the licensee or applicant has:
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> . . .
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> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice dentistry, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of dentistry but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional conduct shall also include any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing dental practice; [or]
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> (10) Violated a statute, law, or any rule or regulation of this state, any other state, the board, the United States, or any other lawful authority (without regard to whether the violation is criminally punishable), which statute, law, or rule or regulation relates to or in part regulates the practice of dentistry, when the licensee or applicant knows or should know that such action is violative of such statute, law, or rule, or violated a lawful order of the board previously entered by the board in a disciplinary hearing, consent decree, or license reinstatement; [or]
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> (12) Displayed an inability to practice dentistry with reasonable skill and safety to patients or has become unable to practice dentistry with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics,

chemicals, or any other type of material, or as a result of any mental or physical condition . . . .

2.

Under O.C.G.A. § 43-11-47(d), if the Board finds any of the violations listed in the statute it may:

> (1) Refuse to grant or renew a license to an applicant;
> (2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;
> (3) Suspend any license for a definite period or for an indefinite period in connection with any condition which may be attached to the restoration of said license;
> (4) Limit or restrict any license as the board deems necessary for the protection of the public;
> (5) Revoke any license;
> (6) Condition the penalty upon, or withhold formal disposition pending, the applicant's or licensee's submission to such care, counseling, or treatment as the board may direct.

3.

Likewise, under O.C.G.A. § 43-1-19(a) a licensing board may also impose sanctions, including the sanction of revocation, upon a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:

> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional conduct shall also include any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing practice of the business or profession licensed under this title; [or]
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> . . .
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> (8) Violated a statute, law, or any rule or regulation of this state, any other state, the professional licensing board regulating the business or professional license under this title, the United States, or any other lawful authority (without

regard to whether the violation is criminally punishable), which statute, law, or rule or regulation relates to or in part regulates the practice of a business or profession licensed under this title, when the licensee or applicant knows or should know that such action is violative of such statute, law, or rule, or violated a lawful order of the board previously entered by the board in a disciplinary hearing, consent decree, or license reinstatement; [or]

. . .

(10) Displayed an inability to practice a business or profession licensed under this title with reasonable skill and safety to the public . . . .

4.

Pursuant to Ga. Comp. R. & Regs. r. 150-8-.01, the Board also has the authority to discipline a dentist in Georgia if that individual has engaged in unprofessional conduct. For the purpose of the implementation and enforcement of this rule, unprofessional conduct is defined to include, but not be limited to, the following:

(h) Any departure from, or failure to conform to, the minimum standards of acceptable and prevailing dental practice. Guidelines to be used by the Board in defining such standards may include, but are not restricted to:

1. Diagnosis. Evaluation of a dental problem using means such as history, oral examination, laboratory, and radiographic studies, when applicable.

2. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction.

4. Records. Maintenance of records to furnish documentary evidence of the course of the patient's medical/dental evaluation, treatment and response. A dentist shall be required to maintain a patient's complete dental record, which may include, but is not limited to, the following: treatment notes, evaluations, diagnoses, prognoses, x-rays, photographs, diagnostic models, laboratory records, laboratory prescriptions (slips), drug prescriptions, insurance claim forms, billing records, and other technical information used in assessing a patient's condition. Notwithstanding any other provision of law, a dentist shall be required to maintain a patient's complete treatment record for no less than a period of ten (10) years from the date of the patient's last office visit.

5.

Based on the aforementioned Findings of Fact, the Board has proven by a preponderance of the evidence its allegations under O.C.G.A. §§ 43-34-37, 43-1-19 and Ga. Comp. R. & Regs. r. 150-8-.01. Dr. Andrews, a specialist in endodontics,

found that Respondent had committed numerous gross violations which fell below the minimum standards of acceptable and prevailing dental practice. At the hearing Dr. Andrews noted that one of root canals performed by Respondent was probably "the worst I have ever seen." Even more egregiously, the records reviewed by Dr. Andrews do not indicate that Respondent told his patients about either the gross violations or of their prognoses. Moreover, Respondent could have rectified some of his errors shortly after making them, but failed to do so. Due to the poor care received from Respondent, Dr. Andrews foresees that many of Respondent's patients will have future dental and/or medical issues. In this case the facts elicited at the hearing make clear that Respondent has engaged in a pattern of practice that subjects the public to far too great a risk of harm and revocation is the only appropriate sanction.

ORDER

Accordingly, it is hereby ordered that Petitioner's proposed decision to **REVOKE** Respondent's license is **AFFIRMED.**

SO ORDERED, this 18 **day of** February, 2015

RONIT WALKER, ALJ