STATE OF VERMONT
OFFICE OF THE SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
APPELLATE OFFICER

IN RE CARMEN M. ALCALA, DMD	)	
	)	
APPEAL FROM BOARD OF	)	
DENTAL EXAMINERS	)	
License No. 016-1175	)	**Docket Nos. 2011-42(DE) and**
	)	**2011-215**

APPELLATE ORDER AFFIRMING DECISION BY BOARD OF DENTAL EXAMINERS ENTERED ON AUGUST 2, 2013

This matter was considered on November 13, 2013. The Appellant, Carmen M. Alcala, DMD, was present and appeared with counsel, Ralph Suozzo, Esq. The State was represented by Edward G. Adrian, Esq. The Vermont Board of Dental Examiners (hereinafter referred to as "the Board") issued a decision on August 1, 2013 following hearings on June 12, 2013 and July 10, 2013. The matter was heard as a contested case with the respondent and several expert witnesses providing testimony. Numerous exhibits were admitted. The Board made extensive findings and an order which suspended the dental license of the Respondent for 180 days; required the completion of a course in clinical practice of 70 hours prior to reinstatement; conditioned her reinstated license for three years with a requirement of independent review of patient files and reporting to the Board; and required a permanent condition that she keep her records in a manner as specifically ordered by the Board. No administrative fine was imposed. The Respondent filed a notice of appeal dated August 23, 2013. The Appellate Officer was appointed pursuant to 3 VSA Sec. 130a. Upon the arguments, the briefs, the exhibits and the record, the Appellate Officer makes the following decision.

Facts

The State alleged that the Respondent performed inadequate and substandard dental treatment to three patients, including poor patient-charting over a time period between 2002 through 2012. The State charged that the Respondent's actions constituted unprofessional conduct under 3 VSA Sec. 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions which includes performance of unsafe or unacceptable patient care and failure to conform to the essential standards of acceptable and

prevailing practice); and also 3 VSA Sec. 129a(a)(3) failure to comply with provisions of federal or state statutes or rules governing the practice of the profession. The Respondent denied that she had committed any unprofessional practice or that she had breached any applicable standard of care. She further answered that the three particular patients were difficult patients with significant dental problems, including self-neglect of their dental care and that they did not follow the good advice of the Respondent.

The evidence consisted of the State offering the testimony of the Respondent and many exhibits, including patient charts, billing records, x-ray slides, and correspondence. The State also offered its expert witness, James Gold, D.D.S., and a fact witness, John W. Summerville, D.D.S. Dr. Summerville testified about his care of patient C.K. subsequent to the treatment by the Respondent. Dr. Gold testified that the care rendered by the Respondent to patient C.D. was "unsafe patient care", "unacceptable patient care", "would not pass the minimal standards of clinical competence" and failed to conform to the essential standards of acceptable and prevailing practice. See June 12, 2013 transcript pp. 199-200. He also described how the patient-charting for this patient was faulty, inconsistent with other records, and not consistent with an appropriate standard of care. Concerning patient N.L., Dr. Gold testified that the work by the Respondent was "less than ideal", (June 12, 2013 transcript, P. 212) clinically inadequate, (P. 213) and that her partial x-rays were unacceptable (P. 214). Again, he noted inadequate charting of periodontal examinations for this patient. Finally, on cross examination Dr. Gold testified generally about the need for patient-charting, and specifically about patients' informed consent forms being included as a minimal standard of competency. (This was not included in the chart for patient C.D.) Dr. Gold noted inconsistencies in all three patients' clinical charts and their billing records.

The Respondent offered the expert testimony of Horace W. Josselyn, D.D.S. Dr. Josselyn testified that the dental care of the Respondent for each of the three patients was not a breach of the standard of care. Concerning the patient-charting, Dr. Josselyn was less clear. He testified that the ideal practice was to include "everything" in the record, but that there was no breach of record-keeping for patient C.D. He was not specifically asked about the record-keeping for the other two patients. He did testify on cross examination that the amount of errors in the Respondent's patient charts were "unacceptable" (July 10, 2013 transcript, P155) and that diagnostic questioning of a patient should be included in the patient's clinical notes (July 10, 2013 transcript, Page 169).

Dr. Alcala (the Respondent) testified for both the State and herself. She explained her evaluation and treatment for each patient. She was of the opinion that her treatment was appropriate given the situation for each patient. She also explained, essentially, that the poor dental condition of each patient, the failure of the patients to follow her recommendations, and their failure to complete follow-up visits with her ... all these compromised her treatment plan. Her testimony was problematic. She repeatedly gave non-responsive and rambling answers which did not address the question which had been asked. Often when she was asked to identify where it showed in her records that a particular treatment was given to a patient, she reiterated what treatment she gave rather than what the record stated. This gave the potential appearance that she was evading the fact that her patient clinical chart did not include the treatment or that the patient chart was inconsistent with her testimony. On numerous occasions she had to be directed by the Presiding Officer to listen to the attorney's question (including her own attorney) and respond only to that question (July 10, 2013 transcript, pages 24, 54, 82 and 125). Consequently, her testimony was convoluted and unresponsive. Her testimony was inconsistent with her patient clinical notes, or other records. Often, her testimony included detailed facts

which were not included in her clinical notes or other records. When confronted with the confusion created by inconsistent chart-notes or other records, she either demurred by saying the clinical record was "As best as they can be", "it is what it is" (June 12, 2013 transcript, Page 29) or "I don't think you're going to find perfect records". (July 10, 2013 transcript, Page 135). At other times she blamed other members of her staff who had made incorrect or inconsistent chart entries or she blamed the computer program which she was using in her office (which she claimed caused dates of records to be confused)(June 12, 2013 transcript, P. 144; July 10, 2013 transcript, pages 131and 135)

One of the most important items of evidence was a previous disciplinary decision by the Board concerning the Respondent entered on October 12, 2004. (Exhibit 13). In the case now before the Board, the Respondent admitted that she had been disciplined in 2004. The 2004 case included "failing to properly document treatment in patient dental records and charts," and thereby had "committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 VSA Sec. 129a(b)(2).[1]

Approximately two weeks after the presentation of evidence in the current case, the Board rendered a detailed, thirteen-page decision which recounted nine pages of facts. The decision clearly shows that the testimony of Dr. Alcala was carefully considered and weighed by the Board. The Board found unprofessional conduct and ordered that the Respondent's license be suspended for 180 days, and that she could be reinstated if she had completed a rehabilitative program (and the Board suggested a 70 hour course). The Board further conditioned her license for three years on a monitoring program where 5 patient files per week would be reviewed by a Board-approved dentist with bi-monthly reports to the Board as to compliance with record-keeping standards of the dentistry profession. Finally, the Board made continuing conditions upon the Respondent's license "for the remainder of her licensed practice in Vermont" directing her manner of record-keeping including the date of entries into the record, the ability to retrieve all of a patient's records from one location, and a prohibition against using "autonotes". It is from this order that the Respondent appealed.

Issues Raised by Appellant

The Appellant has raised the following issues:

(1) With respect to patients C.D., C.K., and N.L., were the findings of the Vermont Board of Dental Examiners clearly erroneous in view of the evidence on the record as a whole, arbitrary of capricious, or a clearly unwarranted exercise of discretion?

(2) Were the sanctions ordered by the Vermont Board of Dental Examiners in its August 2, 2013 decision arbitrary of capricious, characterized by an abuse of discretion, or a clearly unwarranted exercise of discretion?

[1] In the 2004 case, the findings included that Dr. Alcala had failed to properly note work she had performed on May 16, 2002 and April 2, 2002; she failed to document diagnostic tests on September 4, 2002; a dental record failed to show a dental cleaning on April 4, 2002 which in fact occurred on that date. On June 5, 2002 the Respondent's clinical notes failed to identify a "premed for resins". The Respondent's billing records indicated that she did a limited oral examination on July 1, 2002 but the clinical record was only created on July 3, 2002 (two days after the patient visit.) These facts were stipulated and resulted in an agreed decision that the Respondent had violated professional standards, and that her license was suspended for a period of seven days. In addition an administrative penalty of $1,500.00 was imposed; the order also imposed conditions on her license that she complete two courses and that she have independent monitoring of her records for a year.

Decision

Under 26 VSA Sec. 130a, an appellate officer may reverse or remand a case if substantial rights of the appellant have been prejudiced because the findings, inferences, conclusions or decisions are:

(1) in violation of constitutional or statutory provisions;
(2) in excess of the statutory authority of the board;
(3) made upon unlawful procedure;
(4) affected by other error of law;
(5) clearly erroneous in view of the evidence on the record as a whole;
(6) arbitrary or capricious; or
(7) characterized by abuse of discretion or clearly unwarranted exercise of discretion.

In the appeal of an administrative board's decision, the appellant must show that at least one of the above errors has occurred and that "substantial rights of the appellant have been prejudiced." Id. Where administrative action is taken by a group of the appellant's peers, the findings will be affirmed if they are supported by substantial evidence and if the conclusions are rationally derived from the findings and based upon a correct interpretation of the law. Braun v. Board of Dental Examiners, 167 Vt. 110, 702 A.2d 124 (1997). Additional deference to an administrative board decision is given by the appellate authority where the board is made up of professionals in the respondent's profession . The appellate authority may not substitute its own judgment for that of the Board. See Schneider v. Vermont Employment Sec. Bd., 133 Vt. 187, 190, 333 A.2d 104, 106 (1975). The issue in this case is the reasonableness of the Board's decision, not how the appellate authority would have decided the case. See Texas State Bd. of Dental Examiners v. Sizemore, 759 S.W.2d 114, 117 (Tex.1988), cert. denied, 490 U.S. 1080, 109 S.Ct. 2100, 104 L.Ed.2d 662 (1989); Homoly v. North Carolina State Bd. of Dental Examiners, 125 N.C.App. 127, 479 S.E.2d 215, 217 (board composed of licensed dental professionals best qualified to judge whether petitioner violated standard of care).

Evidence is "substantial" if, in looking at the whole record, it is relevant and a reasonable person could accept it as adequate to support the particular conclusion.

Substantial Evidence to Support the Findings, Conclusion, or Inferences

In her brief and in oral argument, the Respondent recounted and reiterated the testimony of Dr. Alcala and her expert, Dr. Josselyn. For example,

> Dr. Alcala testified truthfully and credibly about the care she gave to her three patients under extremely difficult circumstances. The Board did not reasonably consider Dr. Alcala's testimony, but instead made unreasonable, arbitrary determinations based upon what it concluded should have been in her records. *Despite no factual evidence to dispute Dr. Alcala's testimony*, the Board disregarded and discredited Dr. Alcala's testimony about her own patients. This was clearly unreasonable and constitutes an abuse of the Board's discretion. See page 10, Appellant's brief, emphasis added.

To the contrary, the Board heard the testimony of the State's expert which supported the conclusions of the Board of substandard patient care. "[Respondent's] restoration of C.D.'s tooth failed to conform to the essential standards of acceptable and prevailing practice". See

Finding No. 8 and testimony of Dr. Gold, Transcript of June 12, 2013, P. 200. "The margin on the distal portion was clinically inadequate and potentially harmful to [patient] N.L. In the absence of sufficient records, we are forced to conclude that Dr. Alcala's clinical treatment of N.L. failed to conform to the essential standards of prevailing practice." See Finding No. 22. Dr. Gold's testimony, Transcript of June 12, 2013, page 213-214. "Dr. Alcala left N.L.'s teeth #31 and #32 without adequate foundation for crowns. Her preparation failed to provide adequate vertical height to support retention of the temporary crowns. Both crowns required re-cementing for which N.L. was charged. This was unacceptable patient care. Dr. Alcala failed to conform to the essential standards of prevailing and acceptable dental practice." See Finding No. 28. See Dr. Gold testimony, Transcript of June 12, 2013, Page 216.

Even in the absence of expert testimony, it would be possible for an administrative licensing board which included five licensed dentists to evaluate, and pass judgment upon the practice of Dr. Alcala. For example, "Dr. Alcala left it to C.K. to diagnose his own infection and make his own decision of whether antibiotics should be taken. That is not acceptable practice." See Finding No. 21. An administrative board of experts in the profession may "draw its own conclusions based on its members' experience and expertise." In re Lakatos, 2007 VT 114. A board or body whose duty it is to pass upon the qualifications of licensees of the various professions--law, medicine, psychology, or others--must do so by applying some broad and necessarily general standards. Brody v. Barash, 155 Vt. 103, 582 A.2d132 (1990)

Following a review of all the testimony and exhibits, the appellate officer finds that there was substantial evidence to support the findings and conclusions of the board surrounding her treatment of the three patients at issue. Where the credibility of witnesses and conflicting testimony are issues, the trier of fact will not be reversed because one side of the controversy was accepted over the other. See Devers-Scott v. Office of Professional Regulation, 2007 VT 4, 181 Vt. 248, 918 A.2d 230.

The issue of patient-charting in this case was significant. It deserves separate discussion. The appellate officer could find no Vermont Statute or rule which delineates what must be charted by a dentist in his or her care for the patient. Nonetheless, the standard of clinical charting by dentists was addressed by the expert witnesses in this case. The standard was also enunciated and explained in detail by the Board in its decision. As stated by the Board, clinical dental records should be complete, consistent, and accurate. See page 2 of Decision. The clinical records should "... at a minimum, record the patient's subjective symptoms and chief complaints, the dentist's subjective observations clinically and radiographically, and an assessment and differential diagnosis which may include, if appropriate at that time, a suggested treatment plan." See Finding No. 6 The clinical records should be sufficiently clear and understandable so that a dental professional reading the record can determine what treatment had been performed. See Finding No. 14. The clinical records should be accurate and devoid of obvious errors (such as Dr. Alcala referring to the removal of baby teeth and parental consent for an 82-year old patient). See Finding No. 19. The clinical records should document informed consent for the patient and that important diagnostic information was shared with the patient. See Finding No. 22 and testimony of Dr. Gold (Transcript of June 12, 2013, Page 222). Clinical notes should be made "at or near in time of the events they document." See Page 11 of Decision. They should be dated as to the time at which they are entered into the chart. See Page 10 of Decision.

As stated by the expert witnesses in this case, dental records are seldom perfect and it is impractical for the chart to include everything which was said and done during a patient visit. Thus, there must be some discretion in determining whether a dental chart is inadequate. In the

case of Dr. Alcala, there was ample evidence for the Board to conclude that the patient clinical charts for the three patients at issue in this case were grossly deficient. The record and the resulting findings of fact are replete with instances of inadequate clinical charting. At times, Dr. Alcala herself could not make sense of the clinical chart entries (July 10, 2013 transcript, Page 129-131). The Respondent has not pointed to one fact found by the Board concerning record-keeping which was without evidence supporting it. The Respondent argues in her brief that, "The Board's decision is arbitrary and capricious because it was not based upon the facts proven at the hearing but upon alleged errors and omissions in the patients' dental records." See Appellant Brief, Page 11. But the brief does not point to any finding of fact which is without some supporting evidence in the record. The appellate authority is not obligated to search the record for errors raised in the brief but which are unidentified . Quazzo v. Quazzo, 136 Vt. 107, 386 A.2d 638 (1978).

The Respondent, in oral argument and in her brief, discounted the seriousness of poor record-keeping. "...[T]his matter boils down to arguably poor record keeping." See Appellant Brief, page 11. The Vermont Supreme Court has stated the importance of record-keeping in the context of midwifery.

> Additionally, [Respondent] is mistaken in her belief that record-keeping statutes and rules are less significant than other statutes and rules. The structure of the midwifery regulatory regime, and the ALO's findings, clearly demonstrate that diligent and accurate record-keeping and data sharing are crucial to the safety of patients and the legitimacy of midwifery practice. Dismissing the record-keeping requirements and merely ministerial ignores their underlying purpose." Devers-Scott v. Office of Professional Regulation, supra. at Paragraph 52.

The dental statutes and rules do not appear to address record-keeping, but the Board clearly explained the standards and that the profession of dentistry is taught, "If it isn't in the record it didn't happen." Board Decision, Page 11.

When discussing the poor record-keeping, the Board decision stated, "Dr. Alcala chose to intentionally ignore known professional standards. Her record keeping was reckless." See Board Decision, Discussion, page 12. The Respondent argued that there was no evidence of intentional conduct by the Respondent. But for the previous Board findings and professional discipline in 2004, this conclusion of intentional conduct might not stand. Having in mind, however, the recent stipulated findings in the 2004 decision (Exhibit 13), the 2004 findings of poor record-keeping, and the sanction imposed therein, it is a reasonable inference that the Respondent's continued poor record-keeping was intentional and done with clear knowledge that this was contrary to professional standards. She had just been disciplined for similar errors. There had been a recent Board finding that her record-keeping was contrary to professional standards. The records now being reviewed in the current case were her records and her responsibility which she seemed to acknowledge. See July 10, 2013 transcript, Page 133. With all these facts in mind, it was reasonable and logical for the Board to infer that she intentionally kept records which were contrary to known professional standards.

The Sanction

The Respondent argues that the sanction imposed by the Board (180 day suspension, required rehabilitative instruction, independent monitoring of records, and limits on certain manner of record-keeping) was clearly erroneous, arbitrary and capricious, and characterized by an abuse of discretion. At oral argument, the Respondent stated that the expense to Dr. Alcala of the rehabilitative course would be in excess of $10,000.00 once travel and lodging expenses were

included.[2] The Respondent argued further that a six-month suspension was unduly harsh and that lengthy suspensions were reserved for cases of fraud or serious drug abuse.[3] The appellate authority must consider these arguments in light of the deference which the statute gives to the Board. Evidence is viewed in the light most favorable to the prevailing party. In re Central Vermont Medical Center, 174 Vt. 607, 816 A.2d 531 (Vt. 2002). Moreover, the Vermont Board of Dental Examiners is made up of many dentists and dental professionals and, as such, it is given much deference in determining penalties since those professionals are subject to the same sanctions and have no incentive to make the rules or remedies excessively harsh. Cf. O.P.R. v. McElroy, 2003 VT 31, 824 A2d 567 (2002). In general, an appellate authority "will not interfere with the decision of an administrative board made in the performance of a discretionary duty in the absence of a showing of abuse of discretion." Vincent v. Vermont State Ret. Bd., 148 Vt. 531, 536, 536 A.2d 925, 929 (1987).

Concerning the issue of license suspension as a component of any dental licensing order which is designed to protect the public, it is worthwhile to consider the approach of the Board in the case of In re James L. Culver, Docket No. DE 21-0205, quoting from page 2 of the Supplemental Order entered August 12, 2005:

> The Board is charged by the legislature with protecting the public health, safety, and welfare. It is authorized to hold disciplinary hearings. It may find unprofessional conduct whether or not specific injury to a client, patient or customer has occurred. The statutes permit action after conduct which creates a risk of harm. When unprofessional conduct is found, the Board possesses broad discretion to fashion appropriate sanctions. Among available sanctions is license suspension.
>
> A license suspension affects not only the respondent. It conveys messages to the public and to other practitioners. A suspension tells the public that the Board considers certain unprofessional conduct to be of such gravity that to impose a lesser sanction diminishes its seriousness. As such, as suspension informs other practitioners of what can happen if they engage in similar conduct. Another licensee who might be tempted to engage in similar conduct will make a connection between the conduct and the consequences. The suspension protects the public because other licensees learn that similar conduct can carry an unacceptable professional price. While a suspension may appear punitive to the individual involved, even after the fact, the very fact of a suspension makes similar conduct by others less likely. A license suspension is therefore a general deterrent.
>
> A license suspension also serves as a specific deterrent to the Respondent. *He knows that any future similar conduct can result in a more serious sanction against his license.* In this sense, a license suspension serves a rehabilitative function. It provides additional resolve to an individual .... (Emphasis added)

---

[2] This information was not in the record and there was no request to reopen the evidence by the appellant. On the other hand, the appellate officer assumes that the Board of Dental Examiners has knowledge of the costs of rehabilitative courses.

[3] The Respondent provided no authority for this assertion. A review of disciplinary decisions does not support the assertion, however. Most of the Board decisions which are reported on the OPR website are stipulated decisions and are, thus, in a different category than the case now being decided. In a stipulated decision, the Board is asked to approve or disapprove an entire case, including facts and remedy without knowledge of the strength or weakness of the case. The Vermont Supreme Court has held that a stipulated consent order is not persuasive precedent for a contested case such as this one. Devers-Scott v. Office of Professional Regulation, 2007 VT 4, 181 Vt. 248, 918 A.2d 230. Even if a six-month suspension were unusual, the Vermont Supreme Court has held that in regard to professional conduct decisions, "each case must be resolved in the light of all its own circumstances and, except in the broadest sorts of policy concerns, there is no precedential value as between cases." In re Harrington, 134 Vt. 549, 552, 367 A.2d 161, 163 (1976).

Clearly the suspension for seven days of Dr. Alcala in 2004 did not make a sufficient impression upon her to cause a change in her behavior concerning patient-charting. She was not rehabilitated on that issue by the prior sanction.

The argument that a licensing penalty was too "harsh" was raised in an attorney professional misconduct case of In re Melvin Neisner, 2010 Vt. 102 (Dec. 30, 2010). In that case a lawyer argued that the penalty of a one year suspension with conditions on reinstatement was too "harsh" given other decisions by the court and given the circumstances of the case.[4] The court considered four factors in reaching its conclusion: (1) what duty was violated; (2) what was the mental state of the accused; (3) what was the actual or potential injury resulting; and (4) were there aggravating or mitigating circumstances. Concerning Dr. Alcala's case, the Board's decision considered facts pertinent to each of the above factors. The Board explained the duties which were violated and the Board placed particular stress upon the duty and importance of appropriate patient-charting. The Board expressed concern that the mental state of the accused was unresponsive to previous discipline for similar problems and that she showed a general failure to take personal responsibility for the breaches which were clearly shown in the hearing. The Respondent's failure to willingly take responsibility and the Respondent's attempt to shift the blame to her patients and others, were all appropriate things for the Board to consider. See Devers-Scott v. Office of Professional Regulation, supra. The actual and potential injury to patients was addressed in the decision. See Findings of Fact nos. 9, 20, 28 and 29. The importance of patient-charting to the profession generally was considered and discussed by the Board. Finally, the aggravating circumstances of the recent discipline of Dr. Alcala in 2004 was understandably a large factor in the discipline chosen by the Board. See Finding of Fact no. 34. The sanction chosen by the Board was supported by the evidence and was within the sound discretion of the Board.

Conclusion

In summary, Dr. Alcala has not shown any abuse of discretion, unwarranted exercise of discretion, or inferences, findings or conclusions which were clearly erroneous on the record as a whole. None of the findings, conclusions, or components of the sanction were arbitrary or capricious or beyond the discretion of the Board. The appeal is therefore DENIED.

Dated this 25th day of November, 2013.

George K. Belcher
Appellate Officer

11/25/13
Dated Entered

[4] Mr. Neisner had made false statements to the police about an automobile accident in which he had been involved and from which criminal conviction had resulted.

Appeal Rights

A party may appeal a decision of an Appellate Officer or an Administrative Law Officer to the Vermont Superior Court, Washington Unit, Civil Division, by filing with the Docket Clerk a written notice of appeal within 30 days of the date of entry of the order, in the manner provided in the Vermont Rules of Appellate Procedure 3 and 4. A check for the court filing fee, made payable to the Clerk of the Vermont Superior Court, Washington Unit, Civil Division must accompany the filing. Any request for stay pending appeal should be filed with the Superior Court.

STATE OF VERMONT
BOARD OF DENTAL EXAMINERS

In re: Carmen M. Alcala, D.M.D.	}	
License No. 016-1175	}	Docket No. 2011-42(DE)
	}	2011-215(DE)

Decision on
Unprofessional Conduct Charge

Board Members Participating:

John Lavoie, D.D.S.
Edward P. Pantzar, D.D.S.
Gertrude M. Hodge, Public Member
Randall Miller, D.D.S. (did not participate in deliberations)
Dixie Vallie, C.D.A.
Jennie Reed, R.D.H.
Gerald Theberge, D.D.S.
Mimi Kevan, Public Member
David Baasch, D.D.S.

Appearances:
for Prosecution: Edward G. Adrian
for Respondent: Ralph Suozzo

Presiding Officer: Larry S. Novins

Findings of Fact, Conclusions of Law,
and Order

The Board of Dental Examiners held a hearing in the above matter on June 12, 2013 at the Office of Professional Regulation hearing room at Schulmaier Hall at the Vermont College of Fine Arts and on July 10, 2013 at the City Center, both in Montpelier, Vermont.

Background

The prosecution alleges in its Specification of Charges that Dr. Alcala provided three patients with unsafe care or care which failed to conform to the essential standards of prevailing and acceptable dental practice, and that her record keeping failed to meet the essential and prevailing standards of dental practice.

Dr. Alcala denied the claims of unprofessional conduct. She provided a lengthy answer to the charges. At the hearing she testified at length about the treatment she provided to her patients.

Evidence at the hearing consisted of scores of exhibits and the testimony of five witnesses. The prosecution called Dr. Alcala, John W. Summerville, D.D.S., and James Gold, D.D.S. Dr. Alcala testified on her own behalf and also called Horace W. Josselyn, D.D.S. to provide expert testimony.

As spelled out by the parties in their opening statements, the Board's charge in this case is to determine whether Dr. Alcala met acceptable standards for record keeping and for the care she provided to the three patients in question.

Findings of Fact

Based on the evidence presented, the Board finds as follows:

General Observations

Dr. Alcala's record keeping, as viewed through the records of the three patients in question was incomplete, inconsistent, inaccurate, and contradictory. The prosecution in this case was not given all of Dr. Alcala's records before the hearing began. Several times during the hearing Dr. Alcala revealed that certain information was "in my computer" not in the records she provided. Dr. Alcala's record's shortcomings made rendering this decision difficult. Their contradictions and internal inconsistencies undermined the credibility of Dr. Alcala's hearing testimony. We are not charged to do a line by line recitation of every instance in which her records were deficient. We will specifically address some of the deficiencies below.

Determining what treatment these three patients received and whether or not that treatment met acceptable standards was complicated by Dr. Alcala's poor record keeping. Dr. Alcala's attempts to explain treatment her records did not document were themselves inconsistent. When questioned by the prosecuting attorney, and even by her own attorney, her answers were frequently unresponsive. Rather than providing a simple answer to a simple question, Dr. Alcala preferred to provide long narratives explaining what her records meant. It is unclear whether the nature of her answers revealed an attempt to avoid simple answers that hurt her case, or simply show how she converses. Her lengthy narratives did little, however, to clarify what happened. That Dr. Alcala felt lengthy explanations of her notes and treatment were even necessary underscores the infirmities of her records.

More specifically:

1. Dr. Alcala is licensed as a dentist and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. §§ 584, the Administrative Rules of the Board of Dental Examiners, and the Rules of the Office of Professional Regulation. Dr. Alcala maintains a dental practice in Williston, Vermont.

Patient C.D.

2. C.D. did not testify at the hearing. He contacted Dr. Alcala on Sunday, January 9, 2011. He had not been a patient of hers before. He had been a patient of a different dental practice nearby. Nothing in the evidence showed why he contacted Dr. Alcala instead of his other dental provider. Dr. Alcala's clinical notes contain no description of his presenting symptoms. She saw him again to treat his teeth on January 11, 2011.

3. Dr. Alcala created some of the notes for C.D.'s case via "autonotes" or a similar function within her dental software. The entries for C.D. are not individualized to the patient or specific case. Her notes [Exhibit 1] from his January 9, 2011 visit mention an x-ray. "Note 3rd Party X-Ray Image(s) Taken 01/09/11." Her notes do not explain what a "3rd Party X-Ray" is. An X-ray was provided as Exhibit 109 at the hearing. The x-ray was undated. Dr. Alcala's notes contained charting indicating problems with teeth #30 and #31. She provided no treatment that day.

4. Missing from Dr. Alcala's notes for C.D.'s January 9 office visit was C.D.'s subjective report to her. There is no mention of how long C.D.'s symptoms may have lasted, whether he was in pain. There was no history of his problems with those two teeth or the surrounding area. Missing also is a description of what Dr. Alcala observed, what tests, if any she performed. Dr. Alcala's record does not show that any endodontic evaluation was performed. Dr. Alcala's records do not show whether percussion testing was performed, or if not performed, why not. They do not show whether C.D. was sensitive to temperature. Her records do not show why she prescribed pain medication. At one point in her testimony Dr. Alcala testified that she did not do a percussion test. At another point she said she did. The essential standards of acceptable and prevailing dental practice required Dr. Alcala to document the information noted above. Dr. Alcala's records fail to conform to the essential standards of acceptable and prevailing dental practice.

5. Her entry for #30 stated simply: "recommended resin or sedative if no money to pay for permanent filling. Pat [sic] will talk to parent to see if he can scha pat to pay for any work Originally sch for extraction [sic]ove [sic] the phone but at xray and exam tooth needs filling has deep caries. Dr. Alcala witnessed by Meaghan girlfriend. [01/09/11]." For tooth 31, her notes said: "Resin procedure Two Surface Restoration Note: Please read previous note. Same rule applies." What is meant by "previous note" is unknown. Dr. Alcala's records do indicate that she prescribed Tylenol III with Codeine. Her records do not indicate that C.D. was to return for treatment. The essential standards of acceptable and prevailing dental practice require notes that are clear and understandable. Dr. Alcala's notes fail to conform to the essential standards of acceptable and prevailing dental practice.

6. Dr. Alcala's records for the January 9 visit do not show who wrote them. Dr. Alcala's record of C.D.'s January 9 visit is devoid of a provisional or final diagnosis of C.D.'s condition. Finally, Dr. Alcala's record for January 9 contains no explanation of why a "Resin Procedure Two Surface Restoration" would be an appropriate treatment. Her notes do not indicate that she planned to refer C.D. to an oral surgeon for extraction of #32. The essential and standards of prevailing and acceptable dental practice require records which,

at a minimum, record the patient's subjective symptoms and chief complaints, the dentist's subjective observations clinically and radiographically, and an assessment and differential diagnosis which may include, if appropriate at that time, a suggested treatment plan. Dr. Alcala's records fail to conform to that standard.

7. C.D. returned to see Dr. Alcala on Tuesday, January 11, 2011. Dr. Alcala used "autonotes"s again. Her entry for #31 was customized. It contains a description of the treatment rendered. But the entry for #31 was simply copied to apply to #30. The entry for #30 does not reflect that the treatment to that tooth was to a different surface. Her note for #30 was inaccurate. Her records do contain a description of the treatment she provided for #31.

8. Still, her record for January 11 contains no subjective patient report. Her notes contain no mention of an endodontic evaluation. Her notes do not show what information she provided to C.D., nor do they recite what his treatment options were. Her records do not indicate that decay remained after she treated C.D.. Though Dr. Alcala testified at the hearing that her intent was to provide a "sedative restoration," her January 11 record contradicts her. There is no notation that Dr. Alcala intended her treatment of C.D. to be temporary by use of a indirect pulp cap with the remaining decay or filling to be replaced in the future. Dr. Alcala testified she provided an "indirect pulp cap." Her record contradicts her. Her diagnosis code indicates that she provided a permanent restoration. So did her "Patient Transactions" billing record. Dr. Alcala's record is devoid of any explanation of her claimed future plan. Dr. Alcala's testimony that she intended an indirect pulp cap is not credible. At the bottom of her January 11, 2011 narrative are the names Dr. Alcala, Lynn Gould, CDA, EFDA. Who actually made the narrative entry is unknown. Finally, the January 11, 2011 records contain no mention of the patient's post operative outcomes or prognosis for the treatment provided or, what if any follow up plan there would be. From the evidence presented, we find that Dr. Alcala intended to provide a permanent restoration. The restoration was unacceptable. Either she left decay in the tooth, or left an open margin on the restoration. Her restoration of C.D.'s tooth failed to conform to the essential standards of acceptable and prevailing dental practice.

9. After C.D.'s treatment with Dr. Alcala on January 11, 2011, his pain only worsened. On January 12, 2011 C.D. went to the hospital emergency room for treatment. He was treated and released. He described the pain he felt the next afternoon January 13 as "unbearable." He vomited from the pain. C.D. returned to the emergency room and received IV fluids and nausea medicine. (C.D. letter of complaint to Dr. Alcala, undated., Exhibit U).

10. On January 14, 2011 C.D. went to his original dental office for follow up treatment. The records of the dentist who treated C.D. and the x-ray taken there provide clear documentation of C.D.'s condition after Dr. Alcala treated him. Their x-ray shows that after Dr. Alcala's treatment of C.D., his tooth #31 had an open margin at the mesial. The filling did not end on solid tooth structure. The filling also left an undesirable area of decay between the filling and solid tooth structure. Without any notes in the clinical record referring to a desire to place an indirect pulp cap, this restoration is viewed as

substandard. Dr. Alcala's treatment of C.D. constituted unacceptable patient care. Her treatment of C.D.'s tooth #31 failed to conform to the essential standards of acceptable and prevailing dental practice.

11. C.D. wrote a letter of complaint to Dr. Alcala. It is undated. In response, Dr. Alcala on March 15, 2011 wrote a long clinical note "Narrative" entry for C.D.'s records. In it she provided a detailed recitation of her contacts with and treatment of C.D. Much of what appeared in this entry should have been in her January 9 or January 11 clinical notes. The March 15, 2011 entry is self-serving. The timing of their inclusion in the record renders them unpersuasive. Dr. Alcala's late entry does not meet the essential standards of acceptable prevailing dental practice.

12. Later when OPR began an investigation regarding Dr. Alcala's treatment of C.D., Dr. Alcala wrote an exhaustive five page narrative. (Exhibit A). Dr. Alcala's records are too deficient to corroborate her response. Her records of C.D.'s January 9, 2011 and January 11, 2011 visits fell far short of meeting the essential standards of acceptable and prevailing dental practice.

13. At the hearing Dr. Alcala described her records of C.D. as being, "as best as they can be."

Patient C.K.

14. Dr. Alcala's clinical patient notes again appear to have been created, at least in part, by an "autonote" type function in her software program. The entry for October 5, 2009 for tooth #6 states in part, "Patient agreed to do post and core and a crown for the tooth above (see tooth number). Sometimes there is no post space like in this case Dr.Alcala [sic] made access into the palatal canal instead of placing a metal post. Using high speed handpiece or slow speed handpiece removed gutta percha and created an adequate post space , ..." This entry raises more questions than it answers. Did Dr. Alcala place a post? It is not clear who was responsible for that entry. It is entered without a name. If someone other than Dr. Alcala made the clinical notes for her, their veracity may be even more suspect. The entry is factually incorrect in one major aspect: there is no palatal canal in tooth #6. The entry leaves to conjecture whether she used a high speed or slow speed hand piece. Dr. Alcala testified that she placed a fiber post in tooth #6. Her record does not say that she inserted a post, let alone a fiber post. Dr. Alcala's clinical records regarding her treatment of C.K. are so inconsistent and deficient, we cannot tell exactly what treatment was performed.

15. The prosecution's allegations in its Specification of Charges paragraph 10 regarding Dr. Alcala's treatment of C.K. are unclear. It appears the prosecution's position is that Dr. Alcala created a post space for tooth #6, that she did not install a post, but rather installed a flowable composite which was inadequate. Interestingly, Dr. Alcala did not provide, as she did with the C.D. complaint (and N.L. complaint), a separate detailed response to C.K.'s complaint against her. The evidence presented to the Board included a photocopy of an x-ray. It was not of sufficient quality to be interpreted by the Board. Because we

cannot tell what happened with regard to the post, we decline to find that Dr. Alcala did or did not place one, correctly or incorrectly. Our inability to do so results from a lack of credible evidence of what Dr. Alcala did.

16. Dr. Alcala's clinical note for October 5, 2009 continues, "In many cases the patient has decided to go ahead and do the crown on the same day of this appointment. If you see the code 2750 or code 2790 and the narrative for this code then we did the crown procedure." This statement is at best a pro forma gesture toward record keeping. It is confusing and at best a misuse of a vague and uninformative template. Its presence in the record gives no assurance of what this or any patient's treatment was. This type of entry fails to meet the essential standards of prevailing and acceptable dental practice.

17. On April 5, 2010 Dr. Alcala suggested that C.K. may consider as a treatment option a fixed bridge for teeth #3 through #9. Although the prognosis for this type of bridge is guarded, the evidence presented at the hearing was not persuasive enough for us to find that the mere suggestion of the fixed bridge failed to conform to the essential standards of acceptable and prevailing dental practice. Regardless, Dr. Alcala's letter to C.K. on April 7, 2010 did not fully inform him of the potential of success or failure of the procedure. Her communication to the patient did not conform to the essential standards of acceptable and prevailing dental practice.

18. Dr. Gold testified about Dr. Alcala's records for May 4 and May 5 which the x-rays don't corroborate. Dr. Alcala's clinical records refer an absence of teeth on the lower right side. The x-ray of that area contradicts Dr. Alcala's clinical record.

19. Dr. Alcala removed some of C.K.'s teeth and made an immediate denture for him. The notes for each extraction (3, 6, 8, 9, 10, 11) were identical. "Extraction Simple Baby Tooth Parental Consent." These entries were singularly inapplicable to this 82 year old patient. They are inaccurate. As C.K.'s mouth healed, the immediate denture would very likely require a reline. It did require one, and a reline was completed. Seven months later C.K. left Dr. Alcala's care to seek care elsewhere. The appearance of the immediate denture as it was described seven months after its creation is not sufficient to persuade us that Dr. Alcala constructed it improperly. We are not persuaded by our review of the evidence that Dr. Alcala failed to conform to the acceptable and prevailing standards of dental practice in the making of the immediate denture. But, Dr. Alcala's notes regarding the denture were so deficient that determining exactly what happened was impossible. Her notes failed to conform to the essential standards of acceptable and prevailing dental practice.

20. The prosecution alleged that Dr. Alcala prescribed antibiotics to prevent dry sockets. This comes from an "autonote" entry. If the "autonote" entry is accurate, the prescription is improper. One does not prescribe antibiotics to prevent dry sockets. If the "autonote" entry is inaccurate, and what really happened is that Dr. Alcala prescribed antibiotics for potential infection, should one occur, then the record is misleading and confusing. A prescription for antibiotics is not inappropriate as a contingency. Dr. Alcala suggested in

her hearing testimony that she gave C.K. antibiotics to take in case he began to experience fever and chills which she told him would indicate an infection. Her advice was faulty. Fever and chills are symptoms of a much more serious condition. They are not expected of a dry socket or a dental infection. Dr. Alcala left it to C.K. to diagnose his own infection and make his own decision of whether antibiotics should be taken. That is not acceptable practice. We note also that the reason Dr. Alcala gave at the hearing for prescribing antibiotics contradicts what is in her records.

Patient N.L.

21. N.L. came to Dr. Alcala when she broke tooth #14. N.L. was pregnant at the time. She needed a crown. The crown preparation was done on October 10, 2002. N.L. was billed for a root canal that was not performed. Dr. Alcala's clinical notes for October 24, 2002 do not indicate that Dr. Alcala delivered the crown. They reflect only that N.L. was seen that day by the dental hygienist for a full mouth debridement. Yet, according to Dr. Alcala's financial records, a crown was cemented on October 24, 2002. Dr. Alcala's billing records are inconsistent with her clinical notes. They reflect a pervasive state of disarray in Dr. Alcala's records.

22. On August 20, 2003 Dr. Alcala treated N.L.'s teeth. A radiograph shows that Dr. Alcala had cemented a crown on #14 sometime prior to that x-ray. The crown was ill-fitting. The margin on the distal portion was clinically inadequate and potentially harmful to N.L. In the absence of sufficient records, we are forced to conclude that Dr. Alcala's clinical treatment of N.L. failed to conform to the essential standards of acceptable and prevailing dental practice. Dr. Alcala's records do not show that she read the radiograph when it was taken. Nor do they show that she shared its results with her patient. The essential standards of prevailing and acceptable dental practice require the dentist to share this type of information with the patient and document doing so.

23. Regarding paragraph 18 of the Specification of Charges: Because it is not clear from this paragraph what the prosecution alleges as unprofessional conduct by Dr. Alcala, we decline to find any. Dr. Alcala saw N.L. in April, 2006 and at that time did periodontal charting. Dr. Alcala implied that the reason the crowns were not inserted was because N.L. had not returned to her for treatment. Dr. Alcala's records show that N.L. was seen for hygiene purposes three more times between her April 2006 visit and January of 2009 (October 10, 2006, May 3, 2007 and November 5, 2007). Dr. Alcala's chart notes are missing two visits that are listed in her financial records. Dr. Alcala's Patient Transaction records show that N.L. was seen 20 times between 2006 and 2009. Dr. Alcala's attempt to blame her patient is not supported by her own records.

24. Dr. Alcala's exhibit AA, listed N.L.'s oral hygiene in October of 2004 as "fair" with gingival bleeding described as "general." The narrative comment listed, "gen bleeding poh needs improvement also decay recurring around 31 buccal...." Yet, N.L.'s oral heath was listed as "excellent," and the entry for gingival bleeding was "none" in October of 2005 while the accompanying comment said, "wnl multiple areas of decay recommend 6

month recall." In April of 2006, October of 2006, May of 2007, and November of 2007 Dr. Alcala describe N.L.'s oral hygiene as "excellent" with gingival bleeding described as "none."

25. On January 14, 2009 Dr. Alcala began to treat N.L.,'s teeth #31 and #32. The work Dr. Alcala did for those teeth on that date was not periodontic. Dr. Alcala's records for this date contain a generic note which is not specific to N.L. Exactly what treatment Dr. Alcala provided for teeth #31 and #32 is hard to assess because her records are very deficient and lack radiographic corroboration. Dr. Alcala's "autonotes" for that date are inappropriate to the treatment provided. The notes are internally inconsistent. The "autonote" for tooth #31 indicates "final impression taken." Yet, that very same note says at the end, "final impression to be taken." The same internally inconsistent and therefore inaccurate "autonote" was used for tooth #32. Dr. Alcala's January 14 record also stated, "packed chord or lased as needed for impression if any bleeding or pocketing larger than 4.mm." One cannot tell from this entry whether Dr. Alcala packed cord, or used laser, or some combination of both. This entry is but one more example of how Dr. Alcala's records raise more questions than they answer. They do not meet the essential standards of acceptable and prevailing dental practice.

26. Dr. Alcala's January 14, 2009 records make no mention of a gingivectomy. Her January 26, 2009 record states that she performed a gingivectomy on teeth #31 and #32 on January 14, 2009. A third entry on this topic made on February 23, 2009 states, "to whom it may concern at Ins. Company: dos for preps for crowns was 1/14/2009, you may have a claim that states the gingivectomy was done on same day. Dos for gingivectomy was 1/26/2009. The gingivectomy was done on a separate date." Dr. Alcala's record-keeping about the gingivectomy is incoherent. This is emblematic of the problem afflicting her record keeping in general.

27. Dr. Alcala's records for January 26, 2009 contain no recitation that impressions were taken. On February 20, 2009 Dr. Alcala's records state that she took impressions on January 26, 2009. But on March 18, 2009 her notes state simply, "Final impression #30" and "Final Impression #32." Her records provide no detail as to what treatment she rendered on that date. As we review Dr. Alcala's records we ask, "when were the impressions taken?" Her records fail to provide a good answer. We note also that N.L. had no tooth #30. Dr. Alcala's next entry for March 18, 2009 notes, "Next Cement 30 32 With Periapical."

28. Dr. Alcala left N.L.'s teeth #31 and #32 without adequate foundations for crowns. Her preparation failed to provide adequate vertical height to support retention of the temporary crowns. Both crowns required recementing for which N.L. was charged. This was unacceptable patient care. Dr. Alcala failed to conform to the essential standards of prevailing and acceptable dental practice.

29. Dr. Alcala cemented two temporary crowns for N.L. on January 26, 2009. From Dr. Alcala's records it appears that between them they required recementing twelve times at a

cost of well over $1,000.00. The money spent recementing the temporaries would almost cover the cost of a permanent crown.

30. While the patient-related information is frequently generic and confusing, it is clear when it comes to her patient's children: On February 2, 2009 part of the notes read, "Pat was with sone 'all over the place 3 yr old boy' may go to Mater Christi in Burlington pre k." On March 31, Dr. Alcala notes in great detail how N.L.'s son was in the office. Even this entry is unclear in one respect. We can't tell who entered it.

31. From Dr. Alcala's records it appears that payment for the gingivectomy, whenever it was performed, was denied by the insurance company. Dr. Alcala's February 20, 2009 entry showed a letter was sent to the insurance company in an attempt to justify the procedure. She (or someone on her behalf) wrote in N.L.'s notes, "Dr. Alcala does not think the gingivectomy was done as part of the preparation for the crowns. It was also done because there are pockets and also the clasping would have been impossible per the endodontist." Nothing we have seen in Dr. Alcala records of treatment for N.L. shows periodontal probing or charting to corroborate or justify this claim. Nowhere in the records she provided was there proper periodontal charting (six numbers per tooth). A Periodontal Screening and Recording (P.S.R.) is not a substitute for full periodontic charting. If, as Dr. Alcala claimed, there was a proper periodontal examination done, the absence of complete periodontal charting in N.L.'s records is a failure to conform to the essential standards of acceptable and prevailing dental practice.

32. Dr. Alcala implied that she had done no periodontal charting because N.L. had not been seen for a long time. Dr. Alcala attempted to blame the patient for the long period of no charting. Her records contradict her testimony. She had in fact seen N.L. several times in the interim.

33. Paragraph 20 of the Specification of Charges implies that Dr. Alcala had crowns made without having first created new impressions for them. That allegation appears to reflect well-justified confusion brought on, once again, by Dr. Alcala's records. Dr. Alcala had permanent crowns made for N.L. March of 2009. They did not fit her. Nothing more was done pending N.L.'s ability to pay for further work. On December 2, 2010, N.L. spoke with Dr. Alcala's office about interest the office was charging her for the crowns she had not yet received. The assumption in the Specification of Charges that these crowns had been more recently made without new impressions is incorrect. The confusion was created by bad communication and sloppy record keeping in Dr. Alcala's office. The record for December 2, 2010 does not provide an accurate picture of what had happened.

34. Dr. Alcala was disciplined by this Board in 2004 in Docket No. DE 05-0802 and 2006 under the same docket number. Her 2004 discipline resulted from bad record keeping in 2002. Then she failed to indicate whether testing occurred. There were contradictions between her clinical records and billing records. She failed to make chart entries, failed to note medications used, and made records in an untimely manner. Each record keeping deficiency seen in the case before us now occurred after August, 2002 when the earlier

disciplinary matter was commenced.

Conclusions of Law

1. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2)**: The Prosecution has proved by a preponderance of the evidence that Dr. Alcala failed to practice competently. We find that Dr. Alcala's conduct as found above constituted (1) performance of unsafe and unacceptable patient or client care, 3 V.S.A. § 129a(b)(1) and (2) failure to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.

2. **Re: Alleged Violation of 26 V.S.A. § 129a(a)(3)**: 3 V.S.A. § 129a(a)(3) defines unprofessional conduct to include failing to comply with provisions of federal or state statutes or rules governing the practice of the profession. The Specification of Charges alleges violation of only one statute, 3 V.S.A. § 129a(b). Section (a)(3) of that statute does not provide separate or additional grounds for discipline. There is no independent violation of this section of the statute.

Discussion

Dr. Alcala's testimony at the hearing and the quality of the dental records reviewed made it difficult to get a complete picture of what exactly happened for each of the three patients. What was clear, however, was that Dr. Alcala provided unacceptable clinical care to C.D. (tooth #31, Paragraph 10, above) and to N.L. (#14 crown: Paragraph 22; and preparations for tooth #31 and tooth #32: Paragraph 28).

Most troubling in this case was that Dr. Alcala's inadequate records hampered or in some instance completely frustrated our attempts to determine what treatment she provided. Entries that should have appeared in the notes were missing or dated incorrectly. Some records were kept in Dr. Alcala's computer in a different location from the ones she provided. They should have been included in the clinical notes. Not only were Dr. Alcala's notes deficient, her testimony at the hearing displayed an unwillingness or inability to answer the most simple questions posed to her at the hearing. With adequate records, exactly what treatment she provided would have been clear without lengthy questioning.

At many points in our review of her records the Board members deciding this case were simply unable to piece together what actually happened. Dr. Alcala followed no consistent protocol for entering and dating treatment or showing who was creating records. There were obvious breakdowns in communication between the clinical and administrative sides of her office. We could not tell what treatment she really provided or when, what observations she made, or how she assessed her patients' conditions.

Dr. Alcala's indiscriminate use of "autonotes" is troublesome. Some of the entries are clearly inapplicable to the treatments provided. Yet, they are used over and over. Their frequency and clear impropriety bespeak a reckless disregard for proper record keeping. Dr. Alcala's entries should be time stamped. Notes entered after the fact should be time stamped so that it is clear

when they are added.

Accurate and complete records are required to give other dental or other medical providers needed information about a patient. As dentists and other health care professionals are taught, "If it isn't in the record, it didn't happen." The only trustworthy records seen in this case were radiographs which permit us to see exactly what others saw. The absence of information in patient records prompts guessing as to what really happened. From Dr. Alcala's records, it is difficult or impossible to tell exactly what happened. Dr. Alcala's attitude about record keeping is revealed by her statement at the hearing that C.D.'s records are as "best as they can be."

Dental records are generally considered reliable because they are created at or near the time of the events they document. They should be more reliable than witnesses' distant memories. In Dr. Alcala's case however, her records are not reliable. There were multiple instances where Dr. Alcala's hearing testimony contradicted her own records. The many flaws in Dr. Alcala's records render them untrustworthy. Her March 15, 2010 entry into C.D.'s file, three months after she treated him, does not satisfy record keeping requirements. The trustworthiness of records comes, in great part, from the fact that they are made at or very close to the time observations are made and treatments performed. Record entries should not rely on memory.

This Board's charge is to protect the public. To do so we must be able to determine what a licensee has done. In this case, the deficiencies of Dr. Alcala's records are an obstacle to the performance of our duties. A licensing board should not have to guess about a licensee's treatment of her patients. We refuse to do so.

Of particular concern to the Board is how Dr. Alcala, when confronted with an obvious record keeping error, resorted to placing blame on her patients, the computer and computer programs she uses, and her staff. She did not, in the slightest way, take responsibility for the deficiencies in her practice. Nor did she show any remorse for them.

The deja vu aspect of this case is most troublesome. The case before us now is to a great extent a continuation of the bad record keeping from 2002 that was stipulated to in 2004. After that finding of unprofessional conduct, Dr. Alcala's license was suspended for seven days. She was ordered to pay an administrative penalty of $1,500.00. She was required to take remedial courses. And to assure that she was implementing what she should have learned, fifteen of her patient files were to be reviewed for adequacy on three separate occasions by another dentist. Those sanctions did not work.

The last paragraph of that Stipulation and Consent Order should have cured Dr. Alcala's record keeping problems. "17 Respondent understands that this Stipulation and Consent Order will remain part of her licensing file and may be used for purposes of determining sanctions in any future disciplinary matter."

To determine the appropriate sanction in this case we look to Dr. Alcala's unprofessional conduct, whether it was negligent or intentional, her prior disciplinary history, whether the unprofessional conduct occurred as an isolated instance or as part of a pattern of conduct, whether

she appreciates and takes responsibility for the seriousness of her unprofessional conduct.

No mitigating circumstances excuse Dr. Alcala's record keeping. Her failure to learn from her prior experience, compelled education and monitoring is an aggravating factor calling for a greater sanction. After 2004 Dr. Alcala was on notice that her record keeping needed improvement to meet acceptable standards. She ignored that admonition. The record keeping errors seen in this case span almost a decade. They did not result from mere negligence. Dr. Alcala chose to intentionally ignore known professional standards. Her record keeping was reckless.

Our Order is designed to protect the public. It seeks to deter Dr. Alcala specifically and other licensees generally. This Order is necessary to assure confidence in the integrity of the regulatory system. The sanction we impose in this matter takes into account Dr. Alcala's prior record. A lesson not learned after one suspension demands a stronger response.

Order

For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

Dr. Alcala's license is **suspended, effective August 30, 2013 for a minimum of 180 days,** the earliest reinstatement date being March 1, 2014.

After March 1, 2014 her license, upon petition to the Board, may be reinstated if she has shown compliance with the following:

> Dr. Alcala shall successfully complete the Oral Health Enrichment, LLC, rehabilitative program, at her own expense to address the deficiencies in her clinical practice and in her record keeping as set forth above. See, http://www.ohenrichment.org/contactus.html. The Board suggests that the rehabilitative program address crown and bridge procedures (forty hours), restorative dentistry with emphasis on caries removal and the use of direct and indirect pulp caps (20 hours), and the creation and maintenance of proper dental records (ten hours). Successful completion will include a clinical assessment as determined by OHE.

Once reinstated, Dr. Alcala's license shall be conditioned for no less than three years during which time:

> (1) Dr. Alcala shall have a minimum of 5 patient files per week, randomly selected by a dentist approved by the Board in advance, reviewed by that dentist for accuracy and completeness. Dr. Alcala shall take a post-restorative radiograph of each posterior tooth treatment at no cost to her patients. In addition to the random reviews, the radiographs shall be examined by the reviewing dentist. The reviewing dentist shall report to the Board monthly on Dr. Alcala's record keeping and compliance with standards of practice.

(2) During the conditioned period and for the remainder of her licensed practice in Vermont Dr. Alcala shall:

(a) if using a computer based record keeping system, use one showing the date of each entry and is incapable of going back and correcting or adding to entries. When a subsequent entry is made to a client's file, the date of the entry shall be preserved.

(b) keep all patient records in a manner permitting all records to be retrieved on demand from one location, not kept in multiple places as they were before the hearing.

(c) not use "autonotes". This condition shall be a permanent condition. It will remain in place after all other conditions are removed and Dr. Alcala's license is otherwise considered fully "active." Dr. Alcala's records may be inspected to ensure compliance with this condition.

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Dental Examiners. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, Office of Professional Regulation, 89 Main Street, Fl. 3, Montpelier, Vermont 05620-3402 within 30 days of the entry of this Order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Dental Examiners

By: John Lavoie DDS
John Lavoie, D.D.S., Vice Chair

Dated: August 1, 2013

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 8/2/13