STATE OF VERMONT
BOARD OF DENTAL EXAMINERS

In re: William D. McDonald, D.M.D. License No. 016-0000689	} } }	Docket No. DE 02-0706

Amended Order

By motion dated September 26, 2007 the State requested that the Board set a deadline of six months for compliance with the requirement that Dr. McDonald successfully complete an x-ray course.

The State's request that we set a deadline is reasonable. Paragraph 5 of the Order is amended to read as follows:

> 5) Dr. McDonald shall successfully complete a course, pre-approved by the Board, covering appropriate use of x-rays. The course is to be completed no later than April 1, 2008.

Vermont Board of Dental Examiners

By: _____
Wesley Baker, D.M.D.

Dated: October 15, 2007

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 10/15/07

STATE OF VERMONT
BOARD OF DENTAL EXAMINERS

In re: William D. McDonald, D.M.D. License No. 016-0000689	}	Docket No. DE 02-0706

Decision on
UNPROFESSIONAL CONDUCT CHARGES

Board Members Participating:
John Lavoie, D.D.S.
Gertrude M. Hodge
Linda Retchin, R.D.H.
Raymond N. McCandless
Wesley Baker, D.M.D.
Rena Katz Chernick, R.D.H.
Edward Pantzar, D.D.S.

Appearances:
for Petitioner, State of Vermont: Robert H. Backus,
for Respondent: pro se

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 September 12, 2007 at the Office of Professional Regulation hearing room at the National Life Building in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

Two separate complaints brought against Dr. McDonald were heard on September 12, 2007. Each is addressed in its own separate decision. In this case the prosecution alleges that Dr. McDonald, in the course of treating patient M.F. performed a restoration when a root canal was the appropriate treatment, billed incorrectly, failed to inform the patient about the fate of a tooth, failed to perform a distal restoration when it was needed, failed to tell the patient that a

distal restoration was needed, had the patient sign a promissory note prior to extracting a tooth, and performed a restoration after a pulpotomy without taking an x-ray.

Findings of Fact

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

1. Dr. McDonald is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. §§ 767 and 809, 3 V.S.A. §§ 129 and 129(a), the rules of the Board of Dental Examiners and the Rules of the Office of Professional Regulation.
2. In September 2005 Dr. McDonald treated patient, M.F. She was a Medicaid patient. What treatment would be covered and how often she could receive treatment was limited by the program.
3. The patient was also seen by Dr. Steven Brenner.
4. On September 1, 2005 Dr. McDonald saw M.F. He took two films, and a conducted a limited exam. Dr. McDonald's treatment notes for that day indicate caries in teeth # 2, 18 and 19.
5. At that visit Dr. McDonald restored tooth #2 as M.F. requested.
6. On September 13, 2005 Dr. McDonald saw M.F. twice. On the first visit she reported pain and requested that her tooth #18 be extracted.
7. Dr. McDonald diagnosed that tooth #18 had pulpitis. He told M.F. that it might be saved with restorations.
8. Dr. McDonald recognized and warned M.F. that there was a risk that the restoration of tooth #18 would still fail. She decided to try to save the tooth if possible.
9. Dr. McDonald performed restorations on tooth #18 (MO) and also on tooth #19 (MOB).
10. The assertion that "An x-ray taken September 1, 2005 shows that tooth #18 could not have been saved without a root canal" is a clinical judgment, and not one we can find as a fact.
11. Unfortunately, Dr. McDonald's records are not explicit about what he told M.F.
12. While working on tooth #18 Dr. McDonald nicked the pulp. This is indicated in his notes. His notes do not specifically indicate that he informed M.F. that she would suffer pain from this nick. Immediately after the record entry about the nick and its treatment, Dr. McDonald wrote, "Discuss questions of pulpitis." This is one instance of specific documentation of what Dr. McDonald told his patient. This notation would commonly include mention of the implications of pulpitis, including possible pain. We find that Dr. McDonald did discuss that the tooth could be a problem for M.F., complete with pain.
13. Nothing in Dr. McDonald's records indicates he informed M.F. that she also needed a restoration on tooth #19 on the distal surface. Dr. McDonald testified he told her she needed further treatment. We cannot find that he did.
14. Dr. McDonald testified that whatever he writes in his notes is told to the patient so there is no need to write that "the patient was told...." Dr. McDonald's records do not thoroughly and specifically document what he told M.F.

15. Later that same day, September 13, 2005, M.F. returned and complained that the pain in that tooth #18 was "killing" her. Dr. McDonald told her she would have to have a root canal. Dr. McDonald refused to treat M.F. until she signed an agreement to pay Dr. McDonald. With no alternative to continuing in great pain, M.F. agreed to pay. The note in her chart says, "I promise to pay $245 plus $75 for treatment to tooth #18." Only then did Dr. McDonald extract the tooth. Dr. McDonald required M.F. to pay for both the restoration and for the extraction.
16. There was not enough time on September 13 for Dr. McDonald to perform a distal restoration on tooth #19. There is no evidence in M.F.'s notes that Dr. McDonald told her of the need for prompt follow up care.
17. Several months later, on February 22, 2006, M.F. returned to Dr. McDonald with an emergency complaint. He took an x-ray of tooth #19 and performed a restoration.
18. On March 23, 2006 Dr. McDonald performed a large restoration on tooth #14 without first taking a film.
19. We cannot specifically find that Dr. McDonald's conduct worsened M.F.'s dental condition.

Discussion

We note that our deliberations in this case were complicated by the errors in the factual allegations in the Specification of Charges and confusing charges. As in the other case decided this date, Dr. McDonald's record keeping is an important issue. Once again, Dr. McDonald's testimony revealed a picture different from the one painted by the Specification of Charges. As we said in the B.B. case,

> "Dr. McDonald does not fully understand the ***purposes*** patient records serve. Some of the disputes in this case could have been avoided had Dr. McDonald's records been more thorough. They should stand by themselves as unambiguous documentation of what a patient is told. Patient records are indeed a reference for the dentist. They protect the dentist who documents clearly what patients are told. Succeeding medical providers use the records of a dentist who is no longer able to treat a patient. Records are required by licensing statutes to be retained for seven years so that they are available for review in cases like this."

In a case such as this one, where there is almost a total absence of entries in patient records about advice given to a patient, we find it difficult to find that advice was given.

Conclusions of Law

The prosecution alleges that Dr. McDonald's conduct violated two statutes, 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession) and 3 V.S.A. § 129a(b)(2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes failure to conform to the essential standards of acceptable and prevailing practice). No rule violations are alleged in the Specification of

Charges.

Each of the eight counts in the Specification of Charges is addressed below in correspondingly numbered paragraphs.

1) The State alleged in Count I, "By performing a restoration on tooth #18 when the tooth could only be saved by a root canal, Respondent has committed unprofessional conduct." Since we were unable to find as fact that only a root canal could save the tooth, we do not find unprofessional conduct.

2) Our findings about the decision to try to save tooth #18 show that Dr. McDonald's recommended course of treatment was reasonable. Billing for the course of treatment on September 13, 2005 is not unprofessional conduct.

3) Dr. McDonald did discuss the nick with M.F. and that it could cause her pain. We find no unprofessional conduct.

4) On September 13, 2005 M.F. appeared twice for an emergency appointment. The State does not specify at which appointment Dr. McDonald should have performed a distal restoration on Tooth #19. Neither appointment provided sufficient time for that procedure. The procedure did not need to be performed that day. There is no unprofessional conduct.

5) Dr. McDonald should have informed M.F. that tooth number #19 needed a restoration as soon as possible. There is no evidence in M.F.'s notes that Dr. McDonald told her of the need for prompt follow up care. This is unprofessional conduct.

6) The essential standards of the profession do not permit a dentist to require a patient in "killing" pain to sign a note promising payment as a condition to extracting a tooth. This is a matter of professional ethics. This is unprofessional conduct.

7) This count is a duplicate of Count 6.

8) Given the testimony, Count 8 is incomprehensible. We decline to find unprofessional conduct.

We conclude that the unprofessional conduct found in Counts 5 and 6 Dr. McDonald has violated 3 V.S.A. § 129a (b)(2).

Discussion

Dr. McDonald's history of unprofessional conduct leads us to consider to what extent he pays attention to the requirements of the dental profession. In the past he has been ordered to take continuing education (30 hours in 1997). He was issued a warning in 2006. He was ordered to

enroll in and successfully complete the "Simulated Patient Treatment Clinical Exercise," then later was suspended for 14 days in 2005 for failure to comply with that Order in a timely manner.

We note that Dr. McDonald ably represented his position in this case. The materials he submitted to the Office of Professional Regulation were well organized. He appears quite capable of meeting requirements - when he must. Dr. McDonald presented the Board with an impressive listing of continuing education courses. He expressed an interest in becoming a fellow in the American Academy of General Dentistry. Despite his educational efforts, the unprofessional conduct in this case reflects a misunderstanding of the importance of patient records. It is ironic that the unprofessional conduct found in Count 6 was perfectly recorded in M.F.'s chart. Dr. McDonald's history and the facts found in this case suggest that he can sometimes be impetuous. His attitude may generate more trouble for him than anything else.

In arriving at an appropriate sanction in this case, we consider the gravity of the unprofessional conduct, Dr. McDonald's history, and what it will take to promote compliance with professional standards. All of that is balanced by our duty to protect the public health, safety and welfare.

Order

1) For violation of Count 5, Dr. McDonald shall pay a civil penalty of $1,000.00 by March 1, 2008.
2) For violation of Count 6, Dr. McDonald shall pay a civil penalty of $1,000.00 by March 1, 2008.
3) Dr. McDonald shall successfully complete a course, pre-approved by the Board on record keeping no later than June 1, 2008.
4) Dr. McDonald shall successfully complete a course, pre-approved by the Board on ethics no later than June 1, 2008.
5) Dr. McDonald shall successfully complete a course, pre-approved by the Board, covering appropriate use of x-rays.
6) A 90 day suspension of Dr. McDonald's license will be "suspended" so long as he complies with this Order. The Board may, after notice and hearing, take further action should other violations of the statutes and rules occur.

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Dental Examiners.

A party aggrieved by a final decision of the 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, National Life Bldg., North, FL2, Montpelier, VT 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: _____
Wesley Baker, D.M.D., Acting Chair

Dated: September 24, 2007

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 9/26/07