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BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JULIE TSAI, D.D.S. 77 Mapleton Irvine, CA 92620 Dental License No. 51873 Respondent.	Case No. **DBC 2007-88** **ACCUSATION**

Complainant alleges:

PARTIES

1. Richard L. Wallinder, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Dental Board of California (Board).

2. On or about October 30, 2003, the Board issued Dental License Number 51873 to Julie Tsai (Respondent). The Dental License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2008, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 1670 states:

"Any licentiate may have his license revoked or suspended or be reprimanded or be placed on probation by the board for unprofessional conduct, or incompetence, or gross negligence, or repeated acts of negligence in his or her profession, or for the issuance of a license by mistake, or for any other cause applicable to the licentiate provided in this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein."

5. Section 1680 states, in pertinent part:

"Unprofessional conduct by a person licensed under this chapter [Chapter 4 (commencing with section 1600)] is defined as, but is not limited to, any one of the following:

". . .

"(z) The failure to report to the board in writing within seven days any of the following:

(1) the death of his or her patient during the performance of any dental procedure;

(2) the discovery of the death of a patient whose death is related to a dental procedure performed by him or her; or

(3) except for a scheduled hospitalization, the removal to a hospital or emergency center for medical treatment for a period exceeding 24 hours of any patient to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, or any patient as a result of dental treatment. With the exception of patients to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, removal to a hospital or emergency center that is the normal or expected treatment for the underlying dental condition is not required to be reported. Upon receipt of a report pursuant to this subdivision the board may conduct an inspection of the dental office if the board finds that it is necessary.

". . . ."

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6. Section 1682 states in pertinent part:

"In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for:

". . .

"(e) Any dentist to fail to obtain the written informed consent of a patient prior to administering general anesthesia or conscious sedation. In the case of a minor, the consent shall be obtained from the child's parent or guardian."

7. Section 1685 states:

"In addition to other acts constituting unprofessional conduct under this chapter [chapter 4 (commencing with section 1600)], it is unprofessional conduct for a person licensed under this chapter to require, either directly or through an office policy, or knowingly permit the delivery of dental care that discourages necessary treatment or permits clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment, as determined by the standard of practice in the community."

8. Section 125.3, subdivision (a), states, in pertinent part: "Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . . upon request of the entity bringing the proceedings may request the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

REGULATIONS

9. California Code of Regulations, title 16, section 1043.3(b), states in pertinent part:

"The following records shall be maintained:

(1) Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification), medication use, any known or suspected medically

compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.

"...

(3) Written informed consent of the patient or if the patient is a minor, his or her parent or guardian.

FACTS

10. On or about March 9, 2007, Respondent met with G.B., father of five (5) year old J.B., at Respondent's office at State College Dental Group, in Anaheim, California. A treatment plan was formulated that day, a consent form was signed by the father, and an appointment scheduled.

11. The first treatment occurred on March 23, 2007, at Respondent's office. J.B. was sedated with Nitrous Oxide by Respondent, and given other medication. J.B. was placed on a "Papoose Board," used as protective stabilization. There was no signed and dated consent for the sedation administered by Respondent. The Progress Notes stated that Respondent gave J.B. "80 mg Vistaril + 15 mg Versed Consent." The sedation record indicated that 15 mg Diazepam (Valium), not Versed, was given to J.B. Respondent did not record the time the medications were administered. Respondent also did not record J.B.'s age, health status, the last time J.B. had something to eat or drink.

12. J.B.'s second treatment by Respondent occurred on or about April 6, 2007. A prescription for Amoxicillin was given, but Respondent did not document the amount dispensed, the dosage or frequency of administration.

13. J.B.'s third appointment with Respondent occurred on or about June 1, 2007. Respondent was assisted by two dental assistants. J.B. was sedated with Nitrous Oxide. The Sedation Record and Progress Notes indicated that Vistaril and Valium were given to J.B. The patient's chart did not indicate that Versed or additional medication was given to J.B. The time of the administration was not noted. In addition, there was no record of J.B.'s age, weight, health status, and the last time she had something to eat.

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14. While in the dental chair, J.B. vomited twice, and threw up 1/3 of the medication. Additional medication was then administered by Respondent, but there is no record of the type, the amount or the time that it was given.

15. J.B. was placed in the Papoose Board again. Treatment began and two (2) cotton rolls were placed in J.B.'s mouth, one in the upper left quadrant of the mouth and the other in the lower left quadrant. A "bite block" was placed in J.B.'s mouth during the treatment.

16. Respondent held her hand over J.B.'s mouth during the treatment to increase the amount of Nitrous Oxide J.B. was breathing in through her nose.

17. J.B. was crying throughout the procedure. She flailed her arms while in the Papoose Board, and one arm got loose. Respondent continued the treatment.

18. Respondent reached for a hand piece bur in order to finish the composite on the tooth she was working on. While reaching for the bur, one of the cotton rolls went down J.B.'s throat. Respondent attempted to retrieve it, but could not. She tried to use a high speed dental suction, but this also failed. Respondent attempted to maintain J.B.'s airway with her fingers, but was unable to do so.

19. 911 was called. J.B. was removed from the Papoose Board and an oxygen mask placed on her face. A second dentist in Respondent's office looked in J.B.'s mouth and could not see the cotton roll. When the paramedics arrived, J.B. was on the floor in a near unconscious state. A paramedic attempted four or five "backblows." The cotton roll could not be detected or retrieved by the paramedics.

20. The paramedics took J.B. to Anaheim Memorial Hospital where the cotton roll was removed. She was transferred to Children's Hospital of Orange County, where she was declared brain dead on June 3, 2007, two (2) days after receiving her last treatment from Respondent on June 1, 2007. J.B. died on Sunday, June 3, 2007, at or around 3:45 p.m.

21. An autopsy was performed on June 4, 2007, and the cause of death was determined to be "Asphyxia with hypoxic encephalopathy, clinical" due to "upper airway obstruction, clinical" and "foreign body lodgment complicating dental extraction procedure, clinical."

22. Eight (8) days later, on June 11, 2007, Respondent sent a letter to the Board informing them of J.B.'s death.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Unprofessional Conduct)

23. Respondent is subject to disciplinary action under sections 1685 and 1670 in that she was unprofessional in her conduct and grossly negligent as described in paragraphs 11 through 21, inclusive, as follows:

a. Respondent placed a sedated, combative child, J.B., in a protective stabilization device, namely a Papoose Board;

b. Respondent held J.B.'s mouth open with a bite block;

c. Respondent placed an unsecured cotton roll in J.B.'s mouth without a rubbed dam or a properly positioned throat pack;

d. Respondent left the cotton roll in J.B.'s mouth while she covered J.B.'s mouth with her hand to induce J.B. to breath more nitrous oxide through her nose; and

e. Respondent led J.B. to aspirate the cotton roll, which caused an upper airway obstruction, ultimately resulting in J.B.'s death.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence/Unprofessional Conduct)

24. Respondent is subject to disciplinary action under section 1670 and 1685 and Cal. Code Regs., tit. 16, § 1043.3(b) in that she was unprofessional in her conduct and committed repeated acts of negligence as described in paragraphs 11 through 14, inclusive, as follows:

a. Respondent filled out the Sedation Instruction forms incompletely and incorrectly;

b. Respondent did not list the medications to be given J.B. on the Consent for Administration of Oral Sedatives form dated June 1, 2007;

c. Respondent did not obtain J.B.'s parent's signature on the Consent for Administration of Oral Sedative for the medication administered on March 23, 2007;

d. Respondent did not record J.B.'s age, health status, the last time J.B. had something to eat or drink, and the time the medication was administered on March 23, 2007;

e. Respondent did not record J.B.'s age, weight, health status, and the last time J.B. had something to eat on June 1, 2007;

f. Respondent did not properly record what type of medication was administered to J.B. on March 23, 2007, and June 1, 2007; and

g. Respondent administered additional medication to J.B. after she vomited, then did not record the amount and type of medication, and the time the medication was given on June 1, 2007.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Obtain Consent)

25. Respondent is subject to disciplinary action under section 1682(e) and Cal. Code Regs., tit. 16, § 1043.3(b), in that she was unprofessional in her conduct as described in paragraph 11, as Respondent did not obtain J.B.'s parent's signature on the Consent for Administration of Oral Sedative for the medication administered on March 23, 2007.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Incident)

26. Respondent is subject to disciplinary action under section 1680(z) as described in paragraph 22, above, in that she failed to inform the Board of J.B.'s death within seven (7) days of the discovery of J.B.'s passing.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Dental Board of California issue a decision:

1. Revoking or suspending Dental License Number 51873, issued to Julie Tsai;

2. Ordering Julie Tsai to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/28/08

RICHARD L. WALLINDER, JR.
Executive Officer
Dental Board of California
State of California

Complainant

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