

# Seattle Post-Intelligencer

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Fred Quarnstrom a Seattle dentist who recently resigned from the state's dental board, says the handling of three known dental-death cases raises questions about the consistency and thoroughness of the state's review process. (Meryl Schenker / P-I)

## Enough scrutiny in dental deaths?

**Handling of 3 cases raises questions about state's review process**

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**By CAROL SMITH**  
P-I REPORTER

At least three patients have died after dental procedures in the last three years in Washington, and critics say some of the cases weren't examined closely enough by the state's dental disciplinary board.

The Washington Dental Quality Assurance Commission found no wrongdoing in all three cases.

But one case was closed within two weeks after a panel of commission members looked at the dentist's account of what happened and decided not to review any outside documents, such as hospital records. Each of the other cases was investigated, but then closed without charges and therefore without a full hearing by the board.

In one of those cases, the dental board determined there was no basis to take action against the dentist, who is also a doctor, but the state's medical board has filed unprofessional conduct charges against him for the same oral surgery.

Because no action was taken by the dental board in any of the cases, none of the deaths shows up on the state Web site where consumers can check their dentists' histories.

Dental-patient deaths are rare, but consumer advocates say each occurrence should be carefully reviewed

and given a full hearing -- if only to see whether new precautions are warranted.

"When it comes to death cases, the board sure doesn't do well," said Fred Quarnstrom, a Seattle dentist who recently resigned from the dental board. "I think they should go to a hearing. Why is it a secret?"

The handling of the three known cases raises questions about the consistency and thoroughness of the state's review process, Quarnstrom said.

It also highlights that the public, and even other board members, have no way of knowing a death occurred, how well it was investigated, or why it was closed without resorting to full-fledged public records disclosure requests.

A Seattle P-I investigation in 2005 found the board had been slow to act, and had cut deals with some of the state's most complained-about dentists. Since then, several legislative changes have resulted in increased disciplinary activity, state health officials said.

Other states have policies ensuring consistent review of any death case.

"We do a full investigation of every death, no matter what -- it's mandatory," said Theresa Lane, interim chief of enforcement with the California Dental Bureau, which oversees California dentists.

Under California's system, all records, including coroners' reports and hospital records, as well as records from anyone who treated the patient prior or subsequent to the dentist, are reviewed quickly to determine whether there is a public safety issue at stake, she said. "This is serious when people die."

Texas also collects all records in deaths cases before determining whether a dentist breached the standard of care.

Under Washington's system, however, death cases can be closed before an investigation on the basis of the dentist's "self-report," a narrative summary of the events, said Taylor Stair, disciplinary manager for the Health Professions Quality Assurance division of the state Health Department. Additional records are reviewed only if the case is referred for investigation, she said.

Even if a case goes for further review, that investigation is cloaked from public view unless it results in sanctions or formal discipline. The number of deaths from dental procedures in this state is a mystery, since they aren't tallied separately from injuries.

Here are details on the three recent deaths, according to information obtained by the P-I:

- On June 22, 2007, James "Jimmy" Marks, 62, went to Spokane oral surgeon Mark C. Paxton to have teeth extracted in preparation for dentures. He went into cardiac arrest as he was being put under general anesthesia and suffered brain damage. He died five days later.



 zoom

In 2007, James Marks, shown in 1993, went into cardiac arrest as he was being put under general anesthesia in an oral surgeon's office and suffered brain damage. He died five days later.

Paxton, a former dental board member, had previously been sanctioned in 2005 by the board for using unlicensed assistants to administer general anesthesia, a practice he was ordered to stop, according to state records. In 2007, the board concluded he had complied with the order.

- On Oct. 15, 2007, Henry Dillow, 25, had four wisdom teeth pulled by his Seattle oral surgeon, G. Galia Leonard. He died three days later of an aggressive bacterial infection.
- On Sept. 28, 2005, an unidentified 89-year-old woman went to Spokane oral surgeon Terrance L. Hauck to have the rest of her teeth pulled for dentures. She died after being sedated.

Hauck, who also is a physician, sits on the dental board. He is on leave from that position pending the outcome of the medical board's investigation of the case. All three cases were reported to the state by the dentists themselves, as required. Health Department officials said a screening panel of the dental board, usually made up of three dentists and one public member, determined whether the cases proceeded to investigation. (To protect against potential bias, the identities of patients and dentists are kept from the reviewing panels).

In Paxton's case, the panel closed the case without further investigation.

In the other two cases, screening panels referred the matter for investigation. A single dental board member then reviewed the investigation and presented a summary, plus a recommendation to the charging panel.

In each of the two cases, charging panels elected not to issue either a statement of allegations or a charging statement. Had either of those steps been taken, the matter would have been heard before yet another panel, and any resultant sanctions or actions would have been made public, Stair said.

Quarnstrom and others have argued that serious cases, including death cases, should be noted on the public Web site with a brief explanation of how the matter was investigated and why it was closed.

"If it's all done behind closed doors in secret, there's very little chance of the public ever finding out what happened," Quarnstrom said.

In the three dental-patient death cases, screening and charging panels followed the board's protocols, said Health Department spokesman Gordon MacCracken. "Certainly, they're all looked at seriously," he said.

But consumer health advocates argue that health professions' oversight boards need to be more aggressive about discipline, and that consumers should have more easily accessible information about complaints against their providers.

"How can you know if a death is unexpected if it isn't investigated?" said Dr. Sid Wolfe, director of Public Citizen, a Washington, D.C.-based watchdog group.

While professionals said dental deaths are uncommon, it is difficult to know just how rare they are because the state doesn't break out unexpected deaths

that occur as a result of dental procedures in the same way it tracks unexpected deaths in hospitals.

"Although we do have statistics for many places of death -- for example, hospitals, nursing homes, hospices and homes -- other offices, including dentists, outpatient surgical centers fall into an 'other' category," MacCracken said.

Dentists are required to report to the dental board any injury or death that results in hospitalization. The board said there were 11 deaths or injuries in the 2006-2007 biennium, up from seven deaths or injuries reported in 2004-2005. The state doesn't break the numbers down further.

According to the American Association of Oral and Maxillofacial Surgeons, the average rate of anesthesia-related deaths is about 1 in 700,000 visits. Taking the state's population into account, Quarnstrom estimated that the known deaths put Washington's rate above the average, and said that in itself is an argument for more open investigations.

"I'm flabbergasted that they aren't," said Quarnstrom, who served four years on the board.

A full investigation involves reviewing the dentist's records and getting statements from other dentists and relevant parties, such as medical examiners and hospital staff, Stair said.

Procedures used for oversight and discipline of dentists in Washington were the subject of an earlier P-I investigation. Part of that investigation looked at several closed death cases. In two cases, the experts used by the state to investigate those cases later said their reviews were limited to certain aspects of the cases. One said he had serious concerns about the board's decision to close the case.

The Health Department has cracked down on dentists, said Joy King, executive director of the section that oversees dentists.

The board has taken more serious actions, including license suspensions or revocations, she said, against dentists in the last four years as the Legislature has given it more authority to do so.

## **Medical board files charges**

In the Hauck case, the dental board conducted an investigation, but decided the death of his elderly patient did not warrant any disciplinary action, according to state records. Hauck is also a licensed doctor and the state's medical board also investigated, but did file charges.

The medical board accuses Hauck of unprofessional conduct related to her care. The charges focus on Hauck's record-keeping, and questioned his use of sedation drugs and handling of the ensuing crisis when her heart stopped.

Hauck's Seattle attorney, John Versnel, said Hauck disputed the charges and that the state had some of its numbers wrong regarding sedation doses. Hauck is in the midst of settling the matter with the state, Versnel said. "It's coming down to an issue concerning charting."

The medical board said Monday that a settlement in the matter has been reached. No details were immediately available.

The medical board charges say there is no discussion or consideration of her advanced age, history of anemia or recent blood transfusion in Hauck's records. They also allege that Hauck's records did not show he examined her lungs or airway capacity before sedating her, and that his choice of drugs "was excessive for a person of (her) health status."

The dental panel that examined his case, however, found no reason to discipline Hauck and closed the

matter, according to state records.

There's no mention on Hauck's dental credential of any pending case involving his medical credential -- even though the medical investigation was of a patient undergoing a dental procedure.

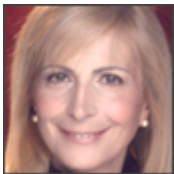
The dental board makes its charging decisions based on the standards of care for the dental profession. Each profession has its own standard of care, Stair said.

At the very least, Wolfe said, the medical statement of charges should be cross-referenced on the dental Web site.

## Lethal bacterial infection

In the Leonard case, the death was the result of a known but rare complication of surgery, the oral surgeon told the P-I.

Leonard would not comment on the specifics of the case, citing patient confidentiality.



Leonard

Dillow, the patient, was otherwise healthy when he had four wisdom teeth pulled. He had the teeth extracted on a Monday, was hospitalized on Wednesday and died the next morning. His death certificate listed sepsis and necrotizing fasciitis as the cause of death, according to his mother, Vicki Dillow.

Necrotizing fasciitis, commonly known as flesh-eating disease, is a lethal type of bacterial infection.

The dental board investigated the case, reviewing hospital records and interviewing treating physicians, then concluded there was no basis to take further action, according to state records.

"To be honest, I would have loved to let my colleagues and everybody know about this very unusual case -- to let people know this complication can still happen," Leonard said.

## Case closed quickly

In the Paxton case, a lawsuit brought the matter to light.

Jimmy Marks, the leader of a prominent Spokane Gypsy family, was a colorful character and household name in Spokane for many years before his death last year.

Marks, who once put a curse on City Hall, was also a sentimental man with a sense of humor, said his lawyer, Russell Jones, who is also a family friend.

Jones is representing Marks' widow in a lawsuit against Paxton, alleging negligence in his death. Marks was overweight and had had both a pacemaker and a defibrillator implanted within the previous year, said Jones.

Experts for the Marks family have raised questions about whether he should have had the procedure under general anesthesia, and whether it should have been done in a hospital.

Seattle attorney Versnel, who also represents Paxton, contends Marks was evaluated correctly, that he was well-informed of his risks and that Paxton, who served on the dental board from 2001 to 2005, was well-trained for such cases.

Paxton's handling of the case was "totally appropriate," Versnel said. "That was the conclusion of the

commission after they did a preliminary investigation."

Paxton has denied the key allegations in the lawsuit.



Paxton

In a letter to Versnel's office, the Health Department's discipline committee stated that a dental board panel reviewed a report submitted by Paxton and decided to close the case "prior to investigation as it does not appear to be a violation of the law."

Jones raised questions about whether the board took that action without reviewing relevant facts. Letters indicate the board received some but not all records from Paxton, and that it had asked for more records, but was turned down by Paxton's attorney.

In a letter to the board dated July 20, 2007, attorneys for Paxton reported Marks had been hospitalized. The letter and attached documents included a summary of events as provided by Paxton, but did not include the fact of his death, said Stair, the case manager who oversees dental cases. The board promptly asked for two additional pages of documents referenced in the letter, but not attached, and was turned down.

In a letter dated July 24, 2007, one of Paxton's attorneys wrote: "Prior to providing any additional information to you, or to any representative of the Department of Health, we require a formal request supported by proper authority. At this time, we will not be providing any additional information as you have not provided authority for your request."

On Aug. 8, the Health Department's disciplinary representative sent Paxton's attorneys a letter notifying them the case was closed.

According to Stair, the panel "put two and two together" after reading reports of Marks' death in the Spokane media and realized the patient had died, but the panel closed the case anyway.

But Jones said key documents related to Marks' medical history, anesthesia risk factors and medications he was currently taking were not supplied to the dental board before they made that decision.

"They closed it without looking at all the records," he said.

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