

UNAPPROVED DRAFT
BOARD OF DENTISTRY
MINUTES
SPECIAL CONFERENCE COMMITTEE "B"

TIME AND PLACE: Special Conference Committee "B" convened on April 25, 2008, at 9:00 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, VA 23233.

APPROVAL OF MINUTES: Ms. Sissom moved to approve the minutes of the Special Conference Committee "B" meeting held on March 14, 2008. The motion was seconded and passed.

PRESIDING: Edward P. Snyder, D.D.S.

MEMBERS PRESENT: Misty L. Sissom, R.D.H.

MEMBERS ABSENT: Darryl J. Pirok, D.D.S.

STAFF PRESENT: Alan Heaberlin, Deputy Director
Gail W. Ross, Adjudication Specialist

QUORUM: Two of the three members of the Committee were present.

**Jamie Ramsay,
D.M.D.
Case Nos. 101814,
113104, 110532**

Jamie Ramsay, D.M.D., appeared with his counsel Jerry Canaan to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that,

1. He may have failed to properly document patient records to include the type and quantity of anesthetic administered in preparation for restorative procedures.
2. He may have failed to include the name of the treating dentist and/or dental hygienist in the patient records.
- 3a. On or about August 20, 2004, he may have failed to diagnose advanced periodontal disease and/or refer Patient A to a periodontist prior to placing a bridge on teeth #6, 7, 8 & 9.
- 3b. On or about August 6, 2004, bitewing x-rays taken by you showed decay on Patient B's tooth #14 which you failed to treat.
- 4a. During his treatment of Patient C, in January of 2005, Dr. Ramsay may have failed to document the patient record to include both a diagnosis the

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- taking of an intraoral x-ray.
- 4b. On or about January 24, 2004, he took a panoramic x-ray and may have failed to maintain it in Patient C’s chart.
 5. While recementing the crown on tooth #3 of Patient D he noted decay, yet failed to remove the decay.
 - 6a. On or about September 2, 2004, he may have placed a pulp cap on E’s tooth #15; however, he documented in the billing ledger that treatment was performed on tooth #14; furthermore, on or about May 30, 2003, he may have failed to document the tooth number that was treated.
 - 7a. In or about May and October 2003, he may have prescribed Tylenol #3 despite the fact that Patient F reported a codeine allergy on her health history.
 - 7b. In or about September 2005, he may have prescribed Vicodin despite the fact that Patient L reported a Vicodin allergy on her health history.
 8. He may have failed to properly treat Patient K’s teeth in that he only performed occlusal restorations despite a previous diagnosis of dental caries affecting the mesial, occlusal and distal surfaces.
 - 9a. During Dr. Ramsay’s treatment of Patient M, he may have failed to administer additional anesthetic or complete root canal treatment when Patient M could not tolerate the procedure.
 - 9b. He may have failed to record the amount of intracanal medication administered to Patient M when he was unable to complete the Root Canal Treatment.
 - 10a. On or about August 7, 2006 he allowed a dental assistant to place a temporary crown on Patient N and may have failed to check the placement of the crown which was improperly placed resulting in an improper occlusion.
 11. During an unannounced inspection of his practice on or about September 19, 2006, the following deficiencies were noted:
 - He failed to display his name at the entrance to the office;
 - He failed to have the radiation safety certificates posted;
 - He failed to obtain written consent from the dental hygienist to practice under general supervision;

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- He failed to consistently retain duplicate laboratory work orders for three years; and,
- He maintained expired atropine sulfate, a Schedule V controlled substance within the working stock.

The Committee received Dr. Ramsay’s statements and discussed the evidence in the case with him.

CLOSED MEETING: Ms. Sissom moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Jamie Ramsay, D.D.S. Additionally, Ms. Sissom moved that Board staff, Alan Heaberlin and Administrative Proceedings Division staff, Gail Ross, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

RECONVENE: Ms. Sissom moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION: Ms. Ross read the Findings of Fact and Conclusions of Law as follows:

Dr. Ramsay holds a current Virginia dental license.

1. Dr. Ramsay violated § 54.1-2706(9) of the Code and 18 VAC 60-20-15(4) of the Regulations, in that, from in or about 2003 to 2007, he failed to properly document the records of Patient A-M to include the type and quantity of anesthetic administered in preparation for restorative procedures.
2. Dr. Ramsay violated § 54.1-2706(9) of the Code and 18 VAC 60-20-15(7) of the Regulations, in that, from in or about 2003 to 2007, he failed to include the name of the dentist and/or dental hygienist providing service for

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Patients A-M.

3. Dr. Ramsay violated § 54.1-2706(5) and (11) of the Code, in that on or about August 20, 2004, he diagnosed advanced periodontal disease on Patient A yet he failed to properly treat the disease and/or refer Patient A to a periodontist prior to placing a bridge on teeth #6, 7, 8 & 9.
4. During Dr. Ramsay's treatment of Patient C he violated § 54.1-2706(9) of the Code and 18 VAC 60-20-15(3) of the Regulations, in that, in or about January 2005, he failed to document the patient record to include a diagnosis when he complained of right sided mouth pain. In addition, during that same visit, the treatment record failed to document that he took an intraoral periapical x-ray of tooth #5, which is indicated in the patient billing ledger.
5. Dr. Ramsay violated § 54.1-2706(9) of the Code and 18 VAC 60-20-15(3) of the Regulations, in that, on or about May 30, 2003, he documented Patient F's billing record to show that he took a periapical x-ray of tooth #14, yet despite noting a toothache in the treatment record, he failed to include the tooth #, and he failed to document the treatment rendered.
6. Dr. Ramsay violated § 54.1-2706(5) and (11) of the Code, in that in or about May and October 2003, he prescribed Tylenol #3 despite the fact that Patient F reported a codeine allergy on her health history, and In or about September 2005, you prescribed Vicodin, despite the fact that Patient L reported a Vicodin allergy on her health history.
7. You may have violated § 54.1-2706(5) and (11) of the Code and 18 VAC 60-20-230 of the Regulations, in that:
 - a. On or about August 7, 2006, you allowed a dental assistant to place a poorly fitting temporary crown on Patient N's tooth #6, which by your own admission, you may have failed to check after placement.
 - b. The patient sought treatment from another dentist, approximately four (4) days later, who informed her that the temporary crown used should go on tooth #8

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- or 9, causing an improper occlusion.
8. During an unannounced inspection of your practice on or about September 19, 2006, the Department of Health Professions' inspector noted the following deficiencies:
- a. You may have violated §§ 54.1-2706(9) and 54.1-2720 of the Code, in that you failed to display your name at the entrance of the office.
 - b. You may have violated § 54.1-2706(9) of the Code and 18 VAC 60-20-195 of the Regulations, in that radiation safety certificates for persons who place or expose dental x-ray film were not posted in plain view of patients.
 - c. You may have violated § 54.1-2706(9) of the Code and 18 VAC 60-20-210.D(2) of the Regulations, in that, on or about July 5, 2006, you failed to obtain written consent from the dental hygienist to practice under general supervision prior to including a general supervision agreement in Patient J's chart.
 - d. You may have violated §§ 54.1-2706(9) and 54.1-2719 of the Code and 18 VAC 60-20-15(8), in that you failed to consistently retain duplicate laboratory work orders for three years, as required.
 - e. You may have violated §§ 54.1-2706(15) and 54.1-3461 of the Code, in that you maintained atropine sulfate, a Schedule V controlled substance, which expired in March 2005, within the working stock.

Ms. Ross reported that the Board found several mitigating factors including the following:

- Dr. Ramsay now completes a daily audit of his charts;
- Dr. Ramsay has reduced his patient load by approximately 25%;
- Dr. Ramsay has changed his health history form to more accurately reflect patient drug allergies;
- Dr. Ramsay has studied the Board of Dentistry's on-line power point presentation regarding medical records;
- Dr. Ramsay has taken and passed the Board's

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dental law exam; and,

- Dr. Ramsay has completed 4 hours of continuing education in record keeping.
- Dr. Ramsay submitted photographs showing that his name is posted in front of his office and the radiation certificates are posted.

The sanctions reported by Ms. Ross were that Dr. Ramsay is issued a Reprimand, he is subject to one inspection within 12 months after the Order is final where five patient records will be copied and reviewed by the Board, He is to take four hours of continuing education in pharmacology, four hours in risk management and four hours of periodontal diagnosis and treatment planning within one year. Furthermore, Dr. Ramsay is subject to a \$3,000 monetary penalty. Ms. Sissom moved to adopt the Committee's decision as reported by Ms. Ross. The motion was seconded and passed.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 11:40 a.m.

Edward P. Snyder, Chair

Sandra K. Reen, Executive Director

Date

Date