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April 23, 2020

By first-class and certified mail no. 7019 1640 0001 0886 4326,
return receipt requested
Gerard Butler, Jr., Esq.
Smith Duggan Buell & Rufo LLP
55 Old Bedford Road
Lincoln, MA 01773

RE: In the matter of Dr. Kallen K. Hull, License No. DN19518
Board of Registration in Dentistry, Docket Nos. DEN-2012-0053 & DEN-2014-0003

Dear Attorney Butler:

Enclosed is the Ruling on Prosecutor's Objection to Tentative Decision ("Ruling") issued by the Board of Registration in Dentistry ("Board") in connection with the matter referenced above. The effective date of the Board's Ruling is the Date Issued.

Sincerely,

Barbara A. Young RDH

Barbara A. Young, RDH
Executive Director
Board of Registration in Dentistry

Enc.

Cc: Prosecution (by interoffice mail)
Administrative Hearing Counsel (by interoffice mail)

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION IN DENTISTRY

In the Matter of Dr. Kallen K. Hull License No. DN19518 Expires March 31, 2022	**Docket Nos. DEN-2012-0053 DEN-2014-0003**

FINAL DECISION AND ORDER

Procedural History

On April 4, 2016, the Board of Registration in Dentistry ("Board") issued Dr. Kallen K. Hull ("Respondent") an Order to Show Cause ("OTSC") requiring him to demonstrate why the Board should not suspend, revoke or otherwise take disciplinary action against his dental license or right to renew such license based on allegations that while Respondent was employed as a dentist at Pediatric Dental Associates, he (1) improperly billed patients[1] or their insurers for more expensive crowns than the crowns actually placed; (2) failed to timely diagnose, document or appropriately treat seven patients' dental conditions;[2] and (3) failed to obtain general informed consent prior to

[1] Improper billing is alleged related to the placement of crowns for Patient A at ¶¶10(e) & (f); Patient B at ¶¶11(m), (n), & (o); Patient C at ¶12(g); Patient D at ¶13(s) & (t); Patient E at ¶14(q); and Patient G at ¶¶16(i), (j) & (k). These allegations were dismissed by the Board on October 4, 2017.

[2] Treatment falling below the standard of care is alleged related to the treatment of Patients A at ¶¶10(c), (g)-(j); Patient B at ¶¶11(e)-(j) & (l); Patient C at ¶¶12(d)-(f) & (h)-(i); Patient D at ¶¶13(d)-(f) & (h)-(p); Patient E at ¶¶14(c)-(o); Patient F at ¶¶15(d)(i); Patient G at ¶¶16(c)-(f) & (h).

commencing treatment for various patients and to otherwise document and update patient medical histories.[3]

Respondent timely answered and requested an adjudicatory hearing. The complaints were assigned to Administrative Magistrate, Beverly Kogut ("AM Kogut"), who over ten days of hearings held between July and August 2018 received evidence and testimony related to the OTSC's allegations. Final arguments were held on October 16, 2018 and the record was closed. A year later on November 1, 2019, AM Kogut issued her Tentative Decision pursuant to 801 CMR 1.01(11)(c). Prosecuting Counsel timely filed objections pursuant to 801 CMR 1.1(11)(c)(1) and Respondent filed responses to Prosecuting Counsel's Objections.

On March 4, 2020, the Board reviewed and carefully considered the Tentative Decision, the Prosecutor's Objection and Respondent's Response to Prosecutor's Objection and issued its Ruling on Prosecutor's Objection. On April 23, 2020, after careful review and consideration of the Tentative Decision and its Ruling on Prosecutor's Objection, the Board makes the following observation:

Paragraph 17 and footnote 11 of the Tentative Decision and Prosecutor's Objection at page 8 need further qualification and clarification. The Tentative Decision acknowledges that Patients A-G's dental records are incomplete. In particular, PDA did not retain a copy of Patient A-G's dental records that existed at the time of Respondent's departure from PDA; specifically, electronic records of chartings and periodontal charts Respondent documented "were updated and revised with new information. These

[3] Informed consent and updating patient medical history is alleged with respect to Patients A, B, C, D, E, F & G.

revisions changed and at times eliminated the version of the chartings and periodontal charts that existed during [Respondent's] treatment of the patients" See ¶¶ 3 and 5.[4]

To the extent the Respondent did not have custody or control of the patient dental records and those records have demonstrably changed since Respondent last worked at PDA, it would be unfair to hold Respondent responsible for the content of dental records that are no longer available to include in the administrative record. However, A.M. Kogut makes a distinction between a dentist *obtaining* a patient's medical history and a dentist *documenting* such medical history obtained; the suggestion appears to be that there are two separate responsibilities and perhaps two separate grounds for liability, i.e., standard of care (failure to obtain/inquire) and record keeping (failure to document). In other words, A.M. Kogut appears to parse the parties' stipulation that Respondent failed to update certain patients' medical histories on multiple occasions to mean that while Respondent stipulates that he failed to update medical histories, such stipulation relates to documenting in the patient record, i.e., record keeping, and not if the Respondent inquired of changes in a patient's medical condition since the last visit, i.e., standard of care, prior to treatment.

For record keeping purposes, it's self-evident that even if an updated medical history were obtained by Respondent, not documenting such updated history in the patient record defeats the purpose of providing subsequent dental providers with "a complete record of all patient contact." See 234 CMR 5.14(1).[5] See also *In the matter of Freeman Maltz, D.M.D.*, DN-94-201, *et al.* (April 13, 2001) ("Based on our findings . . .

[4] References to specific paragraphs (¶¶) or pages (at n) are to the Tentative Decision, unless otherwise noted.

[5] The version promulgated August 20, 2010, contained the same text but its citation was 234 CMR 5.15(1).

above, we find that Respondent failed to obtain and record adequate and proper medical histories for each of five patients in question. Even if Respondent had taken verbal histories from patients . . . , his failure to record such histories would have negated any significant benefit to these patients . . . Moreover, a verbal history provides no information to a successor dentist").

The proposition that if an act is not documented, it didn't happen insofar as record keeping is concerned is a basic precept that does not require an expert's professional judgment. While not disturbing A.M. Kogut's findings under the particular circumstances present in this case—demonstrably changed patient records no longer under Respondent's control—the Board limits the future effect of footnote 11, such that expert testimony is not required to support the basic proposition "if it's not recorded, it didn't happen" as to record keeping.

Rationale for Sanction

After reviewing the Tentative Decision, the Board finds discipline of Respondent's license is warranted for violations of record keeping regulations and standards of care in treating his patients. In fashioning a sanction, the Board is cognizant that the violations found here relate to multiple patients and some violations are consistent across all patients. The Board is also guided by precedent in decisions that involve violations of record keeping with respect to informed consent and dental treatment that falls below the standard of care.

A. Failure to Maintain Patient Records

A few Board cases related to informed consent[6] involve a mix of violations of board regulations and treatment falling below the standard of care and encompass sanctions as divergent as license revocation, see *In the matter of Freeman Maltz, D.M.D.*, DN-94-201, *et al.* (April 27, 2001) (revocation for violations of standard of care, record keeping, informed consent; among other violations in the licensee's treatment of four patients)("*Maltz*"), license suspension, see *In the matter of Dr. Robert D. Brennen*, DN-97-066, *et al.* (May 9, 2002) (suspension followed by probation for violations that include record keeping deficiencies for two patients including failing to obtain informed consent, among other violations related to practice falling below the standard of care)("*Brennen*"), to probation, see *In the matter of Dr. Charles Badaoui*, DN-99-236, et al. (April 17, 2006) (one year probation for deficient patient records for two patients including failure to obtain informed consent, among other allegations)("*Badaoui*"), to reprimand, see *In the matter of Dr. Martin Kaplan*, DN-05-049 (reprimand for failing to obtain informed consent from two minor patients' guardians and failing to document and monitor vital signs during sedation).

Indeed, Respondent's record keeping issues are not confined solely to obtaining and documenting patients' general informed consent and documenting patients' updated medical history. He failed to document Patient A's furcation and fractured mesial root on #19 (¶¶ 22 and 23); with respect to Patient B, Respondent failed to document irrigation

[6] The cases cited to relate to the interpretation of 234 CMR 2.04(17) and obtaining and documenting informed consent prior to treatment occurring before August 20, 2010. These cases don't appear distinguish between general and specific informed consent and, from the treatment discussed in each decision, most likely describe specific informed consent, i.e., providing treatment that deviates from the standard of care in fabricating a denture, see text, infra at *Maltz*; administering anesthesia (local and nitrous oxide oxygen sedation) and extracting teeth, see text, infra at *Brennen*, and providing endodontic treatment, see text, infra at *Badaoui*.

and use of a rubber dam and clamp as well as the type of crown on #4 and type of cement on #30 (¶¶ 29 and 30); with respect to Patient C, Respondent failed to document rationale for prescribing Arestin and failed to document distal notch on #19 (¶¶ 39 and 40). With respect to Patient D, Respondent failed to document margins, occlusion and contacts after cementing tooth #29 (¶¶ 48 and 49) and concerning Patient F, Respondent failed to document decay on tooth #2 and failed to document periodontal exam on #2 prior to placing a crown (¶¶ 73 and 74). A.M. Kogut found that generally the above violations subjected the Respondent's license to discipline under 234 CMR 9.05(1), (2) and (14), but did not find evidence of intention wrongdoing that is "flagrant and extreme or that reflects utter indifference to obligations." See Tentative Decision at 38.

In sum, the Board is confronted with Respondent's record keeping violations that are not so egregious as to require restrictions on his practice, e.g., suspension; however, are not so *de minimis* that resolution with non-disciplinary disposition is justified or appropriate.

In mitigation, Respondent acknowledges his record keeping while at PDA was poor and, in his current private practice, he has implemented policies and procedures to address obtaining and documenting his patients' informed consent and update patients' medical histories. He has also taken continuing education related to record keeping. The Board acknowledges Respondent taking affirmative steps to remediate his record keeping practices and accounts for such in fashioning its sanction.

B. Respondent's Dental Treatment of Patients

A.M. Kogut found Respondent's treatment of some patients fell below the standard of care. In sum, Respondent placed an amalgam restoration on Patient C's tooth #18 with a large mesial overhang and failed to remove such overhang before subsequently placing a crown on that tooth and Respondent failed to address a distal notch on tooth #19 he created. See ¶¶ 40 and 43. Respondent failed to address a distal overhang on Patient E's tooth #12, and Respondent failed to diagnose and address decay on Patient F's tooth #2. See ¶¶ 65 and 73. Respondent failed to diagnose, document and address decay on Patient G's tooth #19 prior to cementing a crown. See ¶ 79.

The Board's precedent related to violations of standards of care in diagnosing and addressing various dental conditions range from periods of suspension for instances of prolonged or significant negligence, See e.g., *In the matter of Dr. Paul Virgadamo*: DEN-2011-0114 and DEN-2011-0144 (six month suspension for failing over two years to diagnose decay in three teeth, among other violations) and *In the matter of Dr. Brian Mangano*: DEN-2012-0027 (four month suspension followed by probation based on failing to expose radiographs for over 24 years, including radiographs before and after licensee's fabrication and placement of a bridge), *In the matter of Dr. Italo Lozada*: DEN-2010-0171 (three months suspension followed by probation for failing to diagnose and properly treat severed lingual nerve arising from the licensee's treatment); or significant departure adhering to the standard of care, see *In the matter of Dr. David Satloff*: DEN-2012-0122, *et al.* (June 22, 2018), to periods of probation or stayed probation for lesser degrees of negligence or less significant deviations from the standards of care in the diagnosis and treatment of dental conditions.

Here, A.M. Kogut found the Respondent failed to diagnose, document and treat certain dental conditions in four patients. These failures to adhere to the standard of care are not so significant or egregious to require some sanction limiting or restricting Respondent's practice of dentistry but are significant enough that discipline is warranted. To be sure, A.M. Kogut found that the patient care violations subjected Respondent's license to disciple for pursuant undermining public confidence in the dental profession, for violation of common law and regulatory prohibitions, 234 CMR 9.05(1); for violation of failing to adhere to the standards of the profession, 234 CMR 9.05(14); and violation of Board regulations, 234 CMR 9.05(2), as well as putting at risk public health, safety, or welfare, 234 CMR 9.05(8).

While not rising to the level of gross misconduct, A.M. Kogut found that Respondent's documentation or treatment of Patients A, B, D, E, F and G fell below the standards of conduct and undermined public confidence in the profession of dentistry or violated common law and regulatory provisions and such violations provide sufficient grounds to permit the Board to find discipline of Respondent's dental license is warranted.

Therefore, in keeping with its duty to promote the public health, welfare, and safety, the Board issues the following order after careful consideration of the Tentative Decision and its Ruling:

ORDER

The Board orders Respondent's license to practice dentistry in the Commonwealth be placed on probation for 14 months, commencing on the Effective Date of this Final Decision and Order ("Probation Period").

(1) Within thirty days of the Effective Date, Respondent shall provide a copy of this Final Decision and Order to all jurisdictions in which he holds or has held a license to practice dentistry.

(i) Respondent shall provide written documentation to the Board demonstrating his compliance with paragraph 1.

(ii) If Respondent is not licensed to practice dentistry in another jurisdiction, he shall submit a signed attestation to the Board stating such.

(2) Respondent shall successfully pass the Board's *Jurisprudence and Ethics Examination* within thirty days after the Effective Date.

(3) Complete six (6) hours of Board-approved remedial continuing education in each of (a) record keeping, (b) diagnosis and treatment planning and (c) operative dentistry. Such continuing education shall be pre-approved prior to registering for the courses and shall be attended in person and not taken online or otherwise as self-study.

During the Probation Period, the Respondent shall comply with the additional conditions:

(4) Respondent shall notify the Board in writing of any change to his address of record within seven (7) calendar days of such change.

(5) Respondent shall not violate any provision of M.G.L. c. 112, §§ 43-53 and 234 CMR.

(6) Commit any act that constitutes deceit, malpractice, gross misconduct in the practice of dentistry, unprofessional conduct, or conduct which undermines public confidence in the integrity of the profession.

(7) Respondent has the burden to prove compliance with the requirements of this Order and his Suspension.

If, during the Probation Period, the Respondent fails to comply with any condition in paragraphs 4-7 above, the Respondent shall be entitled to a hearing as to whether he violated such condition. This hearing shall be conducted in accordance with the State Administrative Procedure Act, M.G.L. c. 30A, §§ 10 and 11 and the Standard

Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 and 1.03 *et seq*. After a hearing, if the Board determines a violation did occur during the Probation Period, it may impose a further sanction, deemed appropriate in its sole discretion. Such sanction may include extension of Respondent's Probation, or a period of license suspension to practice dentistry in the Commonwealth or such other sanction as deemed appropriate in the interest of protecting the public health and welfare.

The Board voted to adopt the Tentative Decision as its Final Decision, as noted above, at its meeting held on April 23, 2020, by the following vote:

In Favor:	Ms. Ailish Wilkie, Ms. Stacy Haluch, RDH, Dr. Paul F. Levy, Dr. Stephen C. DuLong, Dr. Seema Z. Jacob, Dr. Michael A. Scialabba, Dr. Thomas A. Trowbridge, Ms. Jacyn Stultz, RDH, and Dr. Patricia Wu
Opposed:	None
Abstained:	None
Recused:	None
Absent:	None

On April 23, 2020, in accordance with the Board's authority and statutory mandate, the Board voted to issue this Final Decision and Order, by the following vote:

In Favor:	Ms. Ailish Wilkie, Ms. Stacy Haluch, RDH, Dr. Paul F. Levy, Dr. Stephen C. DuLong, Dr. Seema Z. Jacob, Dr. Michael A. Scialabba, Dr. Thomas A. Trowbridge, Ms. Jacyn Stultz, RDH, and Dr. Patricia Wu
Opposed:	None
Abstained:	None
Recused:	None
Absent:	None

EFFECTIVE DATE

This Final Decision and Order becomes effective upon the tenth (10^{th}) day from the date it is issued (see "Date Issued" below).

RIGHT OF APPEAL

Respondent is hereby notified of his right to appeal this Final Decision and Order pursuant to M.G.L. c. 30A, § 14 within thirty days of receipt of this Final Decision and Order.

DATE ISSUED: April 23, 2020

Barbara A. Young RDH

Barbara A. Young, RDH
Executive Director

Notify:

By first-class and certified mail no.
7019 1640 0001 0886 4326,
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By Interoffice mail
Richard Banks, Esq.
Prosecutor
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, 8th Floor
Boston, MA 02108

By Interoffice mail
Beverly Kogut, Esq.
Administrative Magistrate
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, 8th Floor
Boston, MA 02108

Berg at the above address any responses to objections within twenty (20) days of receipt of a copy of the objections.

You should not contact this Administrative Magistrate regarding this Tentative Decision. If a party has an inquiry regarding the Tentative Decision, that party shall notify Chief Board Counsel Berg by email (Vita.Palazzolo@MassMail.State.MA.US) and must "cc" the other party in that email. However, if the inquiry contains confidential information, or if the inquiring party does not have an email or does not know the email address of the other party, then the inquiry shall be made to Chief Board Counsel Berg by mail at the above address with copy of the mailing to the other party.

Any mailing that contains confidential information shall be labelled "Confidential."

Beverly A. Kogut
Administrative Magistrate
Department of Public Health
Office of the General Counsel
250 Washington Street, 2nd Floor
Boston, MA 02108

Tentative Decision issued and filed: November 1, 2019

Notified: RB; GB; VB

FIRST CLASS MAIL AND CERTIFIED MAIL RETURN RECEIPT REQUESTED NO. 7017 1450 0002 2340 7485
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