

**SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD
AND SYLVESTER PARKER, D.D.S.**

Come now Sylvester Parker, D.D.S. ("Licensee") and the Missouri Dental Board ("Board") and enter into this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist will be subject to discipline.

Pursuant to the terms of § 536.060, RSMo 2000, the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under § 621.110, RSMo 2000.

Licensee acknowledges that he understands the various rights and privileges afforded him by law, including the right to a hearing of the charges against him; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against him; the right to present evidence on his own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against him and, subsequently, the right to a disciplinary hearing before the Board at which time he may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against his license. Being aware of these rights provided him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this settlement agreement and agrees to abide by the terms of this document, as they pertain to him.

Licensee acknowledges that he has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause to discipline his license, along with citations to law and/or regulations the Board believes was violated.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this settlement agreement are true and stipulates with the Board that Licensee's license, numbered 2007013252 is subject to disciplinary action by the Board in accordance with the provisions of Chapter 621, Cum. Supp. 2009 and Chapter 332, RSMo.



Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo 2000, for the purpose of executing and enforcing the provisions of Chapter 332.

2. Licensee Sylvester Parker, D.D.S. is licensed by the Board as a dentist, License No. 2007013252. Licensee's Missouri license is current and active.

3. On October 30, 2008, the Board received a complaint against Licensee from [redacted], a former patient. Ms. [redacted] alleges that she went to Licensee to have her upper denture replaced. She alleges that Licensee made the denture too big which resulted in her having "buck teeth." She also alleges that Licensee told her that one of her teeth was abscessed and would need to have a crown placed on it. However, Ms. [redacted] received a second opinion and she alleges she was informed that the tooth "needed to be saved" but she was never informed it was abscessed. Finally, Ms. [redacted] alleged Licensee was very unprofessional.

4. As a result of the complaint, the Board conducted an investigation and invited Licensee to attend its October 22, 2009 Board meeting to discuss the complaint. Licensee appeared at the Board meeting and was represented by counsel. During his appearance, Licensee stated:

- a. He had been in practice for almost 30 years in Mississippi and Missouri.
- b. In all those years there was never a complaint filed against Licensee.
- c. Licensee recalled complainant [redacted]. He stated, as he remembered, she had a tooth that had been endodontically treated, she was concerned about it and it needed to be retreated. He stated he greeted her when she came into the practice and did an exam on her. He stated the exam consisted of the soft tissue. It revealed she had some remaining teeth at the bottom and one that was bothering her. He stated they took an x-ray.
- d. Licensee stated [redacted] wanted a new upper denture so he looked at her upper arch. He stated he looked for sore spots and anything that "looks outstanding." He stated he did not remember the condition of her lower teeth.



- e. As to her diagnosis and treatment as of October 2008, Licensee stated he recommended the x-ray of the tooth that was bothering her and the next time her saw her was when they tried the wax try-in of her denture.
- f. They took the x-ray when she came back in to try in the denture. He stated : alleged that the staff was laughing at her. Licensee says that is not "really possible. There's nothing funny about a person that they're suffering at all." Licensee stated he looked at the x-ray with Drs. Sullivan and Adams and it "definitely had some problems on it."
- g. In response to the question of how the examination, consultation, and treatment process worked in Licensee's office, Licensee stated that "we deal with one patient from the exam, the impressions, the bite, we usually deal with them to that point, then after – if they are getting the – a wax try-in, we deal with that and usually we send it to the lab to be – processed and it's not – it's not all the way – we don't really follow the – we might follow the patient all the way through, but one of us check the patient for when their denture is made."
- h. In reviewing the treatment notes in ; chart, Licensee stated the entries on October 10, 2008 show that he greeted the patient, did an exam and ordered the x-ray. He stated he looked at the old denture and determined she needed a new one. He did not talk to her about implants. He also stated that "since the patient was interested in implants, he ordered the x-ray ... but was specifically interested in the lower tooth that was bothering her."
- i. Licensee then stated that "he thought the lower tooth could be restored." However, he "didn't tell her that." He told her after looking at the x-ray that it needed to either be re-treated or taken out. However, none of that information was in the patient's record. Licensee stated there was a lot missing from the patient's record and he did not properly document.
- j. Licensee stated the other patient charts would be accurate and he does things different today. He stated there would be more writing on them and that he "documented more of what I did."
- k. As to his procedure for making dentures, Licensee stated that he does the exam and determines the condition of the tissue. He stated he looks at the old dentures to determine if they are necessary. He stated his assistant does the impression. He stated he takes the bite, sends it to the lab, and if he is doing a bite check, does so in wax. Then sends it to the lab for



processing. He stated the dental assistant tries the denture in when it is returned from the lab and one of the doctors looks at it. He stated he is looking to see how it fits, to see if it is hitting the tissue too hard and he checks the occlusion. To determine how it is hitting the tissue, Licensee stated he uses disclosing putty on every patient. He stated when checking the occlusion he uses the bite with the occlusal paper and make sure the teeth are hitting evenly.

- I. Licensee stated he did not know why he did not properly document in this case. He stated all three dentists looked at the x-ray and he "might have dropped the ball."

5. Following Licensee's appearance, the Board requested twenty patient records from Licensee to review based on the allegations in Ms. _____'s complaint.

- a. On December 22, 2009, Board Investigator Mark Dudenhoeffer travelled to Licensee's practice in Cape Girardeau, Missouri.
- b. On December 22, 2009, Dr. Sullivan had closed the practice for the holidays but happened to be present when Investigator Dudenhoeffer arrived. Investigator Dudenhoeffer met with Dr. Sullivan, Licensee's employer and the owner of the practice and requested the twenty records from the date Licensee received notification of the complaint.
- c. Dr. Sullivan stated that he wanted to comply with the Board's request but was unable to identify the patient records. Dr. Sullivan contacted his office manager who came into the office to assist in identifying and preparing the records. The office manager explained it would take her time to identify and copy the records. Dr. Sullivan agreed to place the records in the mail by January 4, 2010.

6. On January 7, 2010, the Board received records for twenty of Licensee's patients. The charts were for patients who visited the practice between August and October 2009. The Board reviewed the records and identified quality of care or incompetency concerns regarding Licensee's care in 16 of the 20 patients. In reviewing the records, the Board identified the following concerns:

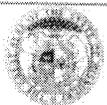
- a. For patient MO patient 1¹, the health history was recorded in January 2007. It was never updated. The 2007 history states MO patient 1 was positive for abnormal bleeding problems,

¹ For the purposes of this Settlement Agreement, all patients will be referred to by the state in which Licensee treated them and a number. The Board will maintain a record identifying the patient name with the corresponding number.



took one aspirin per day and had medically controlled diabetes. No potential concerns related to that health history and surgery were discussed or recorded in the record before a 2009 surgical visit. In September 2009, Licensee extracted 12 teeth using give carpules of anesthetic with epinephrine. There was no diagnosis given in the records, nor any intra or extra-oral examination noted. The records indicate that MO patient 1 was on clindamycin at the time of the September 2009 visit but not record of who prescribed it or why. There was no record of why the teeth were extracted or if alternatives were offered and discussed. The treatment form did not meet criteria for informed consent. MO patient 1 had numerous office visits with serial radiographs dating back to 2007. The radiographs show that the periodontal condition, bone loss, deteriorated dramatically during that time period. There was no record of MO patient 1's periodontal examination, periodontal treatment or consultation at any time. The record for October 5, 2009 states that "patient returning for implant placement." However, there was no record of appropriate implant treatment planning, no record of where they were going to be placed, no consent or alternatives to treatment. The Board determined that the implant protocol in the records was grossly inadequate. The Board also identified gross negligence and incompetence in MO patient 1's treatment. Additionally, the Board determined that the records were not accurate or legible and were not thorough enough for another doctor to be able to understand them.

- b. For patient MO patient 2, the records showed that MO patient 2's medical history indicated that at the time of surgery, MO patient 2 was taking levothyroxin, fluoxetine and lithium. There was no diagnosis information for any of the conditions for which MO patient 2 was taking the medications and no record of a consultation regarding the mental status or possible epinephrine interactions with thyroxin. The records for October 5, 2009 indicate that Licensee ordered four implants for MO patient 2. The records do not reflect informed consent, diagnosis or treatment plan including where Licensee intended to place the implants, and no treatment alternatives. The records for October 19, 2009 reflect that implants were placed but not where they were placed. Records also state the implants were done with three carpules of septocaine with epinephrine. There was no record of an intra or extra-oral examination except one intra-oral



exam form with the box for within normal limits checked and no other information. The Board determined the records were "far below any acceptable standard." There were issues involving dental-medical consultation not dealt with and treatment planning was not handled in a competent fashion. Finally, the implant procedures were grossly inadequate.

- c. For patient MO patient 3, there was no record of examination, diagnosis, treatment plan alternatives, or informed consent. There was one note of an intra oral examination with only the box within normal limits checked. Records state that on August 21, 2009, Licensee fabricated dentures on one day without secondary impressions or bite registration. The treatment technique was not clearly stated in the records. In November 2009, the records indicate MO patient 3 had to have the teeth reset and midline "fixed" due to the "bite being off." The Board determined the records were inadequate as was the denture fabrication technique. The technique was "not even reasonably adequate to expect minimally acceptable results."
- d. For patient MO patient 4, the records show that Licensee remade existing dentures. There is no record of what problems existed with the existing denture, no examination noted, no treatment alternatives noted and no diagnosis. Records for August 17, 2008 do not indicate an acceptable impression technique nor is there record of how or even if the bite registration was made. Record of August 25, 2009 indicates "delivery of dentures no good, bite off." Record also indicates the teeth had to be reset. The medical history was positive for heart attack with stent placement but there was no mention of when. The medical history was also positive for ovarian cancer but no record of when and how it was treated. Finally, there was history of high blood pressure but no record of how high and no record of a blood pressure check at any appointment. The Board determined the records were grossly inadequate as was the treatment technique and no mention of any blood pressure monitoring.
- e. For patient MO patient 5, the records show no record of an examination, diagnosis, treatment alternatives, or informed consent except for one intra oral examination form with only the box within normal limits checked. Patient's medical history indicates high blood pressure but no blood pressure was ever recorded. Licensee fabricated dentures with no secondary impression or wax try-in. The laboratory slip directed the laboratory technician to select the actual teeth to



be used. The Board determined the records were inadequate and the treatment technique improper.

- f. For patient MO patient 6, the patient file included no record of an examination, no treatment plan alternatives, and no record of informed consent except for one form which noted severe "perio" disease. There was no record of how Licensee diagnosed MO patient 6 and no record of a perio exam. However, the record stated Licensee extracted thirteen teeth and fabricated an immediate denture. The Board determined these records were inadequate.
- g. For patient MO patient 7, the records show a medical history of high blood pressure, Hepatitis C and a variety of drugs with possible complications to anesthetic and possible surgical complications. Record does not ever record MO patient 7's blood pressure and never documents a medical consultation. Licensee extracted twelve teeth using seven carpules of septocaine anesthesia. The record does not indicate why the teeth were extracted, there is no diagnosis, there were no alternative treatments records and no examination recorded except for within normal limits. The radiographs do not show significant bone loss or periodontal concerns. Licensee fabricated dentures but did not do or document a secondary impression, bite registration, or wax try. The Board determined that the records were inadequate, there was no medical consultation and unacceptable denture techniques.
- h. For patient MO patient 8, the records demonstrate that Licensee extracted a tooth using septocaine and fabricated dentures. The medical history states MO patient 8 was positive for colon cancer with chemotherapy and radiation, diabetes/kidney failure and one aspirin per day. There was no record of when he was treated for cancer, diabetes/kidney failure and no consultation with any physicians. There were no secondary impressions made, no bite record and no wax try-in. The Board determined the records were inadequate, there was no medical consultation and unacceptable denture technique.
- i. For patient MO patient 9, records indicate Licensee extracted ten teeth using ten carpules of anesthetic and fabricated dentures. There are no exam records except a note of "sever perio disease" but no actual exam to show extent of the disease. Also, no alternative treatment was noted. The treatment records were not clear regarding impression technique or bite



- registration. The Board determined the records were inadequate, it was unacceptable denture technique and Licensee used too much anesthetic.
- j. For patients MO patient 10, MO patient 11, MO patient 12, and MO patient 13, medical records documented upper and lower dentures for all four patients. Patients also all reported high blood pressure which was not taken and recorded in the record. Examination only states the patients want a new lower denture without a basis as to why the new denture. Records contain no secondary impression or wax try-in. The Board determined the records were inadequate, as was the exam, and that it was unacceptable denture technique on each patient.
 - k. For patient MO patient 14, the medical history reveals that the patient was previously on Fosamax. However twelve teeth were extracted using seven carpules of articaine with no physician consultation or discussion regarding possible complications with the patient when extractions and Fosamax can lead to some severely debilitating outcomes. There was no exam noted except severe perio was noted on the chart. No indication of how Licensee arrived at the diagnosis without an examination. The Board determined that the records were inadequate based on the information lacking and that there was no informed consent or consultation.
 - l. For patient MO patient 15, her record reported high blood pressure for which MO patient 15 was on medication to control. However, no blood pressure was taken or noted in the record. MO patient 15 had 26 teeth extracted with six carpules of septocaine. There was no exam noted in the record except the within normal box was checked. There was no diagnosis. The radiograph did not show significant bone loss; showed some caries but salvageable teeth. The Board determined that the records were inadequate; there was a sub-standard evaluation and question why the teeth were all extracted.
 - m. For patient MO patient 16, the medical chart reports a previous joint replacement, high blood pressure and bleeding problems. The exam box was checked "within normal limits" however nine teeth were extracted with no prophylactic antibiotic administered or consulted for; there was no blood pressure evaluation; or bleeding consult. The Board determined the consultation was inadequate and the records were inadequate because of the missing items.



7. Licensee's actions as described in paragraphs 3 through 6 above constitute incompetency, misconduct, or gross negligence in the functions and duties of a licensed dentist in that Licensee failed to maintain proper records, failed to properly document treatment and examination, and failed to have consultation with medical professionals as needed based on patient's stated health history.

8. Cause exists for the Board to take disciplinary action against Licensee's license under § 332.321.2(5), RSMo, which states in pertinent part:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any permit or license required by this chapter or any person who has failed to renew or has surrendered his or her permit or license for any one or any combination of the following causes:

...

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter [.]

Joint Agreed Disciplinary Order

Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of § 621.045.3, RSMo 2000: The terms of discipline shall include that the dental license, license number 2007013252, be placed on **PROBATION** for a period of three (3) years ("disciplinary period"). During Licensee's probation, Licensee shall be entitled to engage in the practice of dentistry under Chapter 332, RSMo, provided he adheres to all of the terms of the Board Settlement Agreement.

I. EDUCATIONAL REQUIREMENTS

- A. Licensee shall take and pass the Board's jurisprudence examination within the first twelve (12) months of Licensee's period of probation. Licensee shall contact the Board office to request a current law packet and permission to sit for the jurisprudence examination no less than thirty (30) days prior to the date Licensee desires to take the examination. Licensee shall submit the required re-examination fee to the Board prior to taking the examination. Failure to take and pass the examination during the first twelve (12) months of the disciplinary period shall constitute a violation of the Board Settlement Agreement.
- B. Licensee shall successfully complete forty (40) hours of education in diagnosis, treatment planning and denture fabrication at Oral Health Enrichment in Cleveland, Ohio within the first one hundred eighty (180) days of Licensee's period of probation. Following completion of the forty (40) hours of education at Oral Health Enrichment, Licensee shall take and pass a written outcome assessment test on the education with a score of at least 80%. Failure to complete the education and pass the



written outcome assessment test on the education within 180 days shall constitute a violation of the Board Settlement Agreement.

II. GENERAL REQUIREMENTS

- A. Licensee shall meet with the Board or its representatives at such times and places as required by the Board after notification of a required meeting.
- B. Licensee shall submit reports to the Missouri Dental Board, P.O. Box 1367, Jefferson City, Missouri 65102, stating truthfully whether he has complied with all the terms and conditions of this Settlement Agreement by no later than January 1 and July 1 during each year of the disciplinary period.
- C. Licensee shall keep the Board apprised of his current home and work addresses and telephone numbers. Licensee shall inform the Board within ten days of any change of home or work address and home or work telephone number.
- D. Licensee shall comply with all provisions of the Dental Practice Act, Chapter 332, RSMo; all applicable federal and state drug laws, rules, and regulations; and all federal and state criminal laws. "State" here includes the state of Missouri and all other states and territories of the United States.
- E. During the disciplinary period, Licensee shall timely renew his license and timely pay all fees required for licensing and comply with all other board requirements necessary to maintain Licensee's license in a current and active state.
- F. If at any time during the disciplinary period, Licensee removes himself from the state of Missouri, ceases to be currently licensed under provisions of Chapter 332, or fails to advise the Board of his current place of business and residence, the time of his absence, unlicensed status, or unknown whereabouts shall not be deemed or taken as any part of the time of discipline so imposed in accordance with § 332.321.6, RSMo.
- G. During the disciplinary period, Licensee shall accept and comply with unannounced visits from the Board's representatives to monitor his compliance with the terms and conditions of this Settlement Agreement.
- H. If Licensee fails to comply with the terms of this Settlement Agreement, in any respect, the Board may impose such additional or other discipline that it deems appropriate, (including imposition of the revocation) following a hearing before the Board.
- I. This Settlement Agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 332, RSMo, by Licensee not specifically mentioned in this document.

III. ADDITIONAL REQUIREMENTS

- A. Licensee shall not allow his license to lapse.
- B. Licensee shall notify, within 15 days of the effective date of this Settlement Agreement, all hospitals, nursing homes, out-patient centers, surgical centers, clinics, and all other facilities where Licensee practices or has privileges of Licensee's disciplinary status. Notification shall be in writing and Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative.



1. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610, 324, RSMo.

2. The terms of this settlement agreement are contractual, legally enforceable, and binding, not merely recital. Except as otherwise provided herein, neither this settlement agreement nor any of its provisions may be changed, waived, discharged, or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge, or termination is sought.

3. Licensee, together with his heirs and assigns, and his attorneys, do hereby waive, release, acquit and forever discharge the Board, its respective members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including but not limited to, any claims for attorney's fees and expenses, including any claims pursuant to § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement, or from the negotiation or execution of this settlement agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this settlement agreement in that it survives in perpetuity even in the event that any court of law deems this settlement agreement or any portion thereof to be void or unenforceable.

5. If no contested case has been filed against Licensee, Licensee has the right, either at the time the settlement agreement is signed by all parties or within fifteen days thereafter, to submit the agreement to the Administrative Hearing Commission for determination that the facts agreed to by the parties to the settlement agreement constitute grounds for denying or disciplining the license of the licensee. If Licensee desires the Administrative Hearing Commission to review this Agreement, Licensee may submit this request to: **Administrative Hearing Commission, Truman State Office Building, Room 640, 301 W. High Street, P.O. Box 1557, Jefferson City, Missouri 65101.**

6. If Licensee has requested review, Licensee and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Licensee's license and issue findings of act and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Licensee's license. Effective the date the Administrative Hearing Commission determines that the agreement sets forth cause for disciplining Licensee's license, the agreed upon discipline set forth herein shall go into effect.



LICENSEE

Sylvester Parker
Sylvester Parker, D.D.S.

Date 26 April, 2011

BOARD

Brian Barnett
Brian Barnett,
Executive Director
Missouri Dental Board

Date 5/2/11

