

**SBDE NO(s). 2018-00283; 2019-00804; 2019-00923; 2019-00955;
2019-01032; 2019-01056; 2019-01211; 2020-00104; 2020-00138 & 2020-00315**

IN THE MATTER OF	§	BEFORE THE EXECUTIVE COMMITTEE
	§	
ERIC JEROME HALL, DDS	§	OF THE TEXAS STATE BOARD OF
	§	
TEXAS DENTAL LICENSE 30724	§	DENTAL EXAMINERS

ORDER OF TEMPORARY SUSPENSION

On the 10th day of December, 2020, an Executive Committee of the State Board of Dental Examiners (Executive Committee) met in an emergency meeting to hear evidence and information in the above-styled case pursuant to section 263.004 of the Texas Occupations Code.

The Executive Committee heard evidence and information that the continued practice of dentistry by Eric Jerome Hall, D.D.S., License No. 30724, would constitute a clear, imminent or continuing threat to a person's physical health or well-being.

The Executive Committee finds, based on the evidence and information presented and the factual and legal bases stated in the Petition for Temporary Suspension, attached and incorporated herein, that the continued practice of dentistry by Eric Jerome Hall, D.D.S., would constitute a clear, imminent or continuing threat to a person's physical health and well-being.

IT IS, THEREFORE ORDERED that the license, and any and all related permits, issued to Eric Jerome Hall, D.D.S., are hereby temporarily suspended pursuant to Section 263.004 of the Texas Occupations Code. This Order is final and effective as of the date of signing.

This matter shall be set for a hearing before the State Office of Administrative Hearings not later than the 30th day after the date the license, and any and all related permits, are suspended by the Order. At that time, the State Board of Dental Examiners will present evidence to show that the license of Eric Jerome Hall, D.D.S. should remain suspended.

During the suspension period referred to above, Respondent SHALL NOT practice dentistry as defined under Section 251.003, Texas Occupations Code, and is prohibited from performing those acts, procedures, and treatments specified under Section 251.003(a)(1)-(10), Texas Occupations Code, in effect at the time of ratification of this Order and any amendments thereafter. Section 251.003(a)(1) and (4) are excepted from this requirement.

Respondent, during this emergency suspension period, may perform only administrative tasks limited exclusively to: opening mail, referring patients, and accepting payments on accounts. During the period of suspension, Respondent SHALL NOT delegate any clinical tasks to any employee or auxiliary and SHALL NOT allow any employee or auxiliary, if any, to practice outside the scope of their permitted duties as defined by the Dental Practice Act and rules and regulations of the Board.

STATE BOARD OF DENTAL EXAMINERS

SIGNED this 10th day of December, 2020.

A handwritten signature in black ink, appearing to read "David Tillman, D.D.S.", written in a cursive style.

David Tillman, D.D.S., Presiding Officer
Texas State Board of Dental Examiners

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IN THE MATTER OF	§	BEFORE THE EXECUTIVE COMMITTEE
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ERIC JEROME HALL, DDS	§	OF THE TEXAS STATE BOARD OF
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TEXAS DENTAL LICENSE 30724	§	DENTAL EXAMINERS

PETITION FOR TEMPORARY SUSPENSION

Now comes the Staff of the State Board of Dental Examiners (Board) and files this Petition for Temporary Suspension (Petition) against Eric Jerome Hall, DDS (Respondent), Texas Dental License No. 30724, based on alleged violations of the Dental Practice Act (the Act), Tex. Occ. Code §§ 251.001 *et seq.* and Board Rules, 22 Tex. Admin. Code §§ 101.1 *et seq.*

In support of this Petition and based upon reasonable information and belief, Staff states the following:

JURISDICTION

1. The Board has authority and jurisdiction over Respondent's dental license and sedation permits pursuant to Tex. Occ. Code §§ 251.001 *et seq.* and 22 Tex. Admin. Code §§ 101.1 *et seq.*
2. Respondent's dental license was in full force and effect at all dates and times material and relevant to this Petition. Respondent's license is currently in active status. Respondent currently holds a Nitrous Oxide, Level 1 Minimal sedation, and Level 2 Moderate Enteral sedation permits.
3. Section 263.004 of the Act requires the Board or an executive committee of the Board to temporarily suspend a person's license or permits if it determines that the continued practice of dentistry by the person would constitute a clear, imminent, or continuing threat to the person or another person's physical health or well-being.

FACTUAL ALLEGATIONS

Board Staff has received information and based on that information believes that Respondent has engaged in conduct in violation of the Act and Board Rules. Board Staff further believes that this conduct shows that this petition and the relief requested are necessary to protect the health and public interest of the citizens of the State of Texas. Based on such information and belief, Board Staff alleges:

1. From November 15, 2016, through August 28, 2019, Respondent fell below the minimum standard of care with respect to seven patients.
 - a. For Patient 1, Respondent:

- i. administered excessive amounts of local anesthesia with epinephrine to the high-risk patient, including 10 carpules of local anesthetics (4 carpules of 2% lidocaine with 1:100K epinephrine, 2 carpules of 4% prilocaine with 1:200K epinephrine, 1 carpule of 0.5% bupivacaine with 1:200K epinephrine, and 3 carpules of 4% articaine with 1:100K epinephrine) on November 28, 2016 during the extraction of three teeth and the placement of two implants;
 - ii. failed to self-report the patient's hospitalization;
 - iii. failed to maintain and review an initial medical history, including the patient's usage of Coumadin, prior to commencing surgical treatment;
 - iv. failed to consult and receive a medical clearance for the patient prior to performing dental surgery; and
 - v. failed to take post-operative radiographs after placing implants for Patient 1.
- b. For Patient 2, Respondent:
- i. administered excessive amounts of local anesthesia with epinephrine, including 21 carpules of local anesthetics (5 carpules of 2% lidocaine with 1:100K epinephrine, 2 carpules of 2% lidocaine with 1:5K epinephrine, 4 carpules of 0.5% bupivacaine with 1:200K epinephrine, 4 carpules of 4% Septocaine with 1:200K epinephrine, 6 carpules of 4% Septocaine with 1:100K epinephrine) on December 6, 2018, during full mouth extraction surgery and the placement of eight implants;
 - ii. failed to obtain vital signs at the initial appointment;
 - iii. failed to provide a thorough diagnostic work-up for a full-mouth rehabilitation case prior to commencing surgical treatment;
 - iv. failed to diagnose the source of the patient's pain prior to placing dry-socket paste;
 - v. repeatedly prescribed the same antibiotic (amoxicillin, 500 mg) on December 3, 2018, and January 8, 2019; and
 - vi. improperly placed eight implants.
- c. For Patient 3, Respondent:
- i. administered excessive amounts of local anesthesia with epinephrine, including 29 carpules of local anesthetics (13 carpules of 4% Septocaine with 1:100K epinephrine, 4 carpules of 4% Septocaine with 1:200K epinephrine, 4 carpules of 0.5% bupivacaine with 1:200K epinephrine, 6 carpules of 2% lidocaine with 1:100K epinephrine, 2 carpules of 2% lidocaine with 1:5000 epinephrine) during the extraction of seventeen teeth and placement of four implants on June 26, 2018; and 12 carpules of local anesthetics (6 carpules of 4% articaine with 1:100K epinephrine, 2 carpules of 4% prilocaine with 1:200K epinephrine, 1 carpule of 2% Lidocaine with 1:100K epinephrine, 3 carpules of 0.5% Bupivacaine with 1:200K epinephrine) during the seating of four implants on June 18, 2019;
 - ii. failed to provide a pre-diagnostic work-up for a full-mouth rehabilitation case prior to initiating treatment;
 - iii. failed to obtain adequate informed consent for the removable prostheses and extraction of seventeen teeth;

- iv. failed to refer the patient to a specialist after implants at site numbers 8, 9, and 11 failed;
 - v. repeatedly prescribed the same antibiotic (amoxicillin, 500 mg) on January 9, 2019, January 21, 2019, and June 13, 2019;
 - vi. failed to provide a proper diagnosis pertaining to the lower right quadrant prior to initiating second stage surgery;
 - vii. exposed the patient to excessive radiation by taking a total of sixteen (16) panoramic radiographs and CT scans within a 14-month time period from June 26, 2018, through August 18, 2019;
 - viii. failed to inform the patient of his elevated systolic blood pressure measurements prior to dental surgery on February 12, 2019, and June 18, 2019;
 - ix. quadrupled the initial dosage amounts for amoxicillin and clindamycin without justification;
 - x. failed to recognize that proper implant integration needs a longer period of time than fourteen (14) days;
 - xi. applied excessive torque (45 Newton centimeters) during implant insertion;
 - xii. failed to recognize that hard tissue needs at least ninety (90) days for proper healing prior to placement of a new implant after an implant fails; and
 - xiii. failed to perform pre-operative physical assessments prior to dental surgical procedures.
- d. For Patient 4, Respondent:
- i. failed to provide a pre-diagnostic work-up for full mouth rehabilitation prior to implant surgery;
 - ii. unnecessarily exposed the patient to excessive radiation by repeatedly taking panoramic radiographs and CT scans; and
 - iii. failed to inform the medically-compromised patient of his elevated systolic blood pressure on August 27, 2018, before surgery.
- e. For Patient 6, Respondent:
- i. failed to perform a limited physical evaluation at the initial appointment;
 - ii. failed to provide a thorough diagnostic work-up for a full mouth rehabilitation case, including but not limited to the use of surgical guides, which ultimately led to multiple implant failure;
 - iii. improperly placed multiple implants;
 - iv. failed to assess the physical status of the high-risk patient, and relevant pre-operative requirements prior to treatment(s) with oral sedation;
 - v. prescribed clindamycin despite the patient's recorded medical allergy;
 - vi. repeatedly prescribed the same antibiotic (amoxicillin, 500 mg) on March 15, 2017, May 8, 2017, September 8, 2017, February 1, 2018, November 30, 2018, December 18, 2018, February 8, 2019, and July 3, 2019, thereby subjecting the patient to the likelihood of antibiotic resistance to amoxicillin.
- f. For Patient 7, Respondent:
- i. administered excessive amounts of local anesthetics with epinephrine, including 17 carpules of local anesthetics (4 carpules of 2% lidocaine with 1:100K epinephrine, 4 carpules of 4% prilocaine with 1:200K epinephrine,

- 5 carpules of 0.5% bupivacaine with 1:200K epinephrine, 4 carpules of 4% articaine with 1:100K epinephrine) during the extraction of twenty-seven teeth and eight implants on August 20, 2018;
- ii. failed to obtain vital signs at the initial appointment;
 - iii. failed to provide a thorough diagnostic work-up for full-mouth rehabilitation; improperly placed implants at site numbers 6 and 7;
 - iv. prescribed amoxicillin (500 mg) on February 7, 2019 despite the patient's reported allergy to penicillin;
 - v. failed to assess the patient's physical status and relevant pre-operative requirements prior to oral sedation;
 - vi. failed to refer the patient to a specialist when the patient developed rashes.
- g. For Patient 10, Respondent:
- i. failed to take pre-operative radiographs and/or CBCT imaging prior to performing dental implants and oral surgery; and
 - ii. prescribed Amoxicillin (500 mg) despite the patient's allergy to penicillin.
2. From November 15, 2016, through August 28, 2019, Respondent failed to make, maintain, and keep adequate records during the treatment of seven patients. Specifically, the records did not include documentation of:
- a. For Patient 1:
 - i. a written review of the patient's medical history and limited physical evaluation;
 - ii. adequate treatment notes regarding the extractions of three teeth and placement of two implants; or
 - iii. an explanation why the items were not recorded.
 - b. For Patient 2:
 - i. vital signs at the initial appointment or an explanation why vital signs were not obtained;
 - ii. written review(s) of the patient's medical history;
 - iii. findings deduced from radiographs and CT scans taken;
 - iv. injection sites for local anesthetics administered;
 - v. sites for suture placement;
 - vi. number of carpules of local anesthetics and concentration of epinephrine administered during the second-stage surgery performed on January 8, 2019;
 - vii. type of impressions taken on January 9, 2019;
 - viii. manufacture identification label for the eight implants placed;
 - ix. the tooth number adjacent to the manufacturer implant identification;
 - x. adequate informed consent with specified teeth and teeth site numbers for surgical extractions and dental implants;
 - xi. physical assessment of the patient prior to performing surgical procedures; or
 - xii. an explanation why the items were not recorded.
 - c. For Patient 3:
 - i. findings deduced from radiographs and CT scans;
 - ii. a written review of the medical history;

- iii. injection sites for local anesthetics administered;
 - iv. sites for suture placement;
 - v. types of impressions taken throughout treatment;
 - vi. adequate treatment notes;
 - vii. adequate sedation checklist(s) and sedation records;
 - viii. complications, such as the failure of tooth number 9;
 - ix. justification for repeatedly prescribing Decadron to the patient;
 - x. manufacturer identification label for the second implant seated at site number 9 on January 9, 2019;
 - xi. adequate informed consent for surgical extractions and implants with the teeth and implant teeth site numbers specified;
 - xii. physical assessment of the patient, including heart rate, prior to initiating surgical procedures; or
 - xiii. an explanation why the items were not recorded.
- d. For Patient 4:
- i. findings deduced from radiographs and CT scans taken;
 - ii. a written review of the patient's medical history;
 - iii. injection sites for local anesthetics administered;
 - iv. sites for suture placement;
 - v. adequate treatment notes;
 - vi. patient's physical status prior to initiating surgical procedures;
 - vii. adequate informed consent for extractions and implants with the teeth and implant teeth site numbers specified; or
 - viii. an explanation why the items were not recorded.
- e. For Patient 6:
- i. vital signs during the initial and throughout surgical procedures or an explanation why vital signs were not obtained;
 - ii. findings deduced from radiographs and CT scans taken;
 - iii. written review of the patient's medical history;
 - iv. injection sites for local anesthetics administered;
 - v. sites for suture placement;
 - vi. number of carpules and concentration of epinephrine through multiple surgical procedures;
 - vii. type of impressions taken;
 - viii. adequate treatment notes;
 - ix. adequate informed consent with specific teeth and site numbers for extractions and implants;
 - x. pre-operative physical status prior to surgical procedures;
 - xi. confirmable identification of provider dentist on record entries; or
 - xii. an explanation why the items were not recorded.
- f. For Patient 7:
- i. vital signs during the initial appointment or an explanation why vital signs were not obtained;
 - ii. a written review of the medical history;
 - iii. findings deduced from radiographs and CT scans;
 - iv. injection sites for local anesthetics;

- v. sites for suture placement;
 - vi. manufacture identification label for implant placed at site number 7 for the second time and for the additional implant seated;
 - vii. complications, including the missing implant at site number 6;
 - viii. adequate treatment notes;
 - ix. adequate informed consent with specific teeth and teeth site numbers for extractions and implants;
 - x. physical status of the patient prior to initiating surgical procedures; or
 - xi. an explanation why the items were not recorded.
- g. For Patient 10:
- i. complete treatment notes;
 - ii. pre-operative and post-operative radiographs and/or CBCT imaging;
 - iii. notation of implant placement parameters, such as motor speed, irrigation, or torque values, for the implant replacement procedures at teeth site numbers 23 and 26; or
 - iv. an explanation why the items were not recorded.
3. During the time period from March 10, 2017, through the present, Respondent engaged in dishonorable conduct with respect to eight patients. Specifically, Respondent:
- a. sedated Patients 6 and 7 beyond his Level 2 sedation permit level during dental surgery;
 - b. violated the duty of fair dealing by failing to provide alternative treatment options, including a referral of complex cases to a specialist, with respect to Patients 2, 3, 4, 6, and 7 prior to commencing treatment;
 - c. abandoned Patients 5, 7, and 10 without providing notice of his intent to discontinue treatment; and
 - d. failed to provide dental records to a patient upon request by Patient 1.
4. On or about August 28, 2019, through the present, Respondent engaged in dishonorable conduct by failing to cooperate with multiple Board investigations. Specifically, Respondent failed to provide:
- a. patient records for Patient 8 and 9;
 - b. complete patient records for Patient 10;
 - c. proof of completion of twelve (12) hours of continuing education; and
 - d. proof of completion of Advanced Cardiac Life Support (ACLS) training upon repeated requests by Board staff.

Respondent's practice of dentistry constitutes a clear, imminent, and continuing threat to a person's physical health or well-being.

LEGAL AUTHORITY

1. The conduct described above represents grounds for discipline under Tex. Occ. Code §§ 258.154(a), 258.155(b), 263.002(a)(3), (4), (10); and 22 Tex. Admin. Code §§ 107.105(a)-(b), 108.2(a), (b), (d), (e), 108.5, 108.6(2), 108.7(1), (2), (3)(A), (7), (12), (14), 108.8(b)(4),

(5), (c)(1)-(8), (11), (12), (f), (g), 108.9(6), (11), 110.5(b)(1), (c)(1), (2)(C), (D), (5), (d), 110.13(a),(c)(1), (3), (4), (d).

2. Section 263.004 of the Act authorizes the Board to temporarily suspend a person's license or permit.

PRAYER

Staff requests that the Executive Committee of the Board determine that Respondent has engaged in conduct that shows that the continued practice of dentistry by Respondent would constitute a clear, imminent, or continuing threat to a person's health or well-being. Staff further requests that the Executive Committee enter an *Order of Temporary Suspension* suspending Texas Dental License No. 30724 and/or Respondent's sedation permits pursuant to Section 263.004 of the Texas Occupations Code.

Filed this 10th day of December, 2020.

Respectfully submitted,

TEXAS STATE BOARD OF
DENTAL EXAMINERS



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