BEFORE THE WEST VIRGINIA BOARD OF DENTISTRY

WEST VIRGINIA BOARD OF DENTISTRY,

COMPLAINANT,

V.

CASE NOS. 2020-DB-0027D
2020-DB-0033D
AND 2021-DB-0038D

CHARLES L. WYLIE, DDS,
LICENSE NO. 2926,

RESPONDENT.

CONSENT AGREEMENT AND ORDER

NOW COME the West Virginia Board of Dentistry ("Board") and Charles L. Wylie, DDS ("Respondent") for the purpose of agreeing to disciplinary action which shall be taken against Respondent in the above-referenced matter. As a means of compromise, the Board and Respondent hereby agree to resolve this matter by and through a voluntary agreement and consent to disciplinary action, with consideration given to appropriate safeguards for protection of the public.

WHEREAS, Respondent acknowledges that the Board has filed a Statement of Charges alleging that he has violated certain provisions of W. Va. Code §§ 30-4-1 *et seq.* and W. Va. Code R. §§ 5-1-1 *et seq.*, and may proceed to a hearing and seek disciplinary action in this matter.

WHEREAS, the parties mutually desire to settle this matter without further prosecution and a formal hearing.

WHEREAS, the Board agrees and acknowledges that this agreement is a compromise of

claims disputed by Respondent.

THEREFORE, it is hereby STIPULATED and AGREED between the undersigned parties that this matter be settled and resolved, the parties having reached an understanding concerning the proper disposition of the matter in controversy, and the Board, approving such an agreement, does hereby FIND and ORDER as follows:

FINDINGS OF FACT

1. Respondent is a licensee of the Board, holding License No. 2926, and at all times relevant, practiced dentistry in Glen Dale, West Virginia.

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2. On October 19, 2020, the Board received a written complaint from an individual identified herein as "M.M." regarding the dental care that she received from Respondent, specifically what was supposed to be the replacement of crowns and the performance of root canals. M.M. reported that, when she arrived at her appointment for her root canals, Respondent informed her that her roots were so infected that he advised pulling the two teeth and placing one implant device instead of performing the root canals. M.M. stated that she followed Respondent's recommendation, and further stated she informed Respondent that she smoked, but that Respondent advised her that her smoking would not be a problem. M.M. stated that Respondent then pulled her two teeth, implanted the device, and provided pain medication.

3. M.M. reported that she returned to see Respondent the following week because she was concerned about a "knot/bubble" that had developed. M.M. stated that Respondent numbed the affected area, advised he was irrigating the site, and then "pushed a needle in several different places and had the dental hygienist pushing the wand against it[,] [a]lmost as if trying to pop a pimple." M.M. reported that she experienced pain following the procedure, and that within

approximately two weeks, Respondent decided to remove the device, which "would allow any infection to drain and would allow the gum and bone to heal."

4. M.M. stated that shortly after removal of the device, Respondent's dental office was closed due to Covid and M.M. developed a small hole in her gum. M.M. reported that over the next several months while Respondent's dental office remained closed, the hole in her gum grew and when she returned to Respondent when his office reopened, it was discovered that she had bone fragments in her gum. Thereafter, Respondent "put a temporary piece over the missing tooth." M.M. reported that she sought the opinion of another dental provider and learned that she had a small piece of tooth left in her gum.

5. By letter dated November 5, 2020, the Board transmitted a copy of M.M.'s complaint to Respondent and requested that he provide a written response, as well as M.M.'s patient records, within thirty (30) days. Respondent requested an extension of time to respond to the complaint, which the Board granted. Thus, Respondent's response was due on December 21, 2020.

6. On April 16, 2021, the Board received a written response from Respondent, through his attorney. In his response, Respondent stated that he realized that M.M. was "a heavy soda drinker, smoker, mouth breather, and was on medications that dried out her mouth," and that he further realized M.M. "was a mouth with unstoppable decay running rampant." Respondent stated that due to the rapid decay, he determined that "doing root canal treatment in teeth already severely damaged almost to the bone was not an ethical thing to do," and that he explained to M.M. why he believed an implant would be beneficial. Respondent maintained that he also advised M.M. that implants could fail and what procedure he would undertake if the implant failed.

7. Respondent stated that the implant "initially integrated and looked good," but after approximately one week, a small pimple formed and the area was treated for infection. Respondent explained his observation of M.M.'s mouth, and why he decided to remove the implant. Respondent then provided a detailed explanation of the dental care he provided M.M. and the rationale for the care. Respondent stated that he believed "what the other doctor thought was a piece of tooth was a piece of bone that had been partially surrounded by soft tissue, as seen in [an] x-ray, taken 6/3/2020, posterior right periapical including #2, #3, and the area #4 and #5, and that that appearance is what would be expected from someone who had had some bone sequestration."

8. The Board's Complaint Committee reviewed M.M.'s complaint, Respondent's response thereto, and the medical records and other documents submitted therewith and obtained during investigation.

9. Upon recommendation of the Complaint Committee, the Board, by majority vote at its meeting on October 22, 2021, found probable cause to believe that Respondent improperly implanted the stud in M.M.'s mouth, failed to remove M.M.'s entire tooth, and failed to diagnose M.M., in violation of W. Va. Code §§ 30-1-8(a), 30-4-19(g)(3), (12), W. Va. Code R. § 5-5-4, and the *American Dental Association Principles of Ethics & Code of Professional Conduct* § 2. Accordingly, the Board determined there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

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10. On November 12, 2020, Drs. Bryan Weaver and William Marshall conducted an evaluation and inspection of Respondent and his dental facility to determine whether Respondent's Class 3B anesthesia permit should be continued. Drs. Weaver and Marshall noted

that Respondent's equipment evaluation and case evaluation were unsatisfactory, and thus concluded that Respondent's permit should be denied.

11. Based on Drs. Weaver and Marshall's evaluation and inspection, by letter dated November 17, 2020 and sent via e-mail and certified mail, the Board notified Respondent that his dental facility failed the November 12, 2020 evaluation and inspection. Accordingly, the Board commanded that Respondent cease and desist using dental anesthesia, with the exception of local anesthesia, until Respondent and his dental facility could be re-inspected and pass evaluation.

12. On December 2, 2020, Dr. Marshall notified the Board via e-mail that he had received an anonymous telephone call in which the caller stated that Respondent had performed sedations in his office on November 24, 2020 and December 1, 2020, and that Respondent had sedations scheduled for December 2, 2020 and December 3, 2020.

13. By letter dated December 9, 2020, the Board notified Respondent that it initiated a complaint against Respondent and requested that he provide a written response within thirty (30) days. The Board informed Respondent that "[p]erforming sedation on patients without a valid anesthesia permit would be a violation of the Board's statutes and rules."

14. On or about December 9, 2020, Respondent was served with a Subpoena Duces Tecum issued by the Board. Pursuant to the Subpoena Duces Tecum, the Board requested the following from Respondent: "[n]ame of each and every current employee of Wylie Dental Care and the home address and home/mobile phone number for each such employee;" "[s]chedules or like documents, dated November 12, 2020 to present, showing patient appointments and procedures scheduled/performed at Wylie Dental Care;" and "[f]or any patient sedated by Dr. Charles Wylie on or after November 12, 2020 to present, a complete copy of the patient's records

held by Wylie Dental Care, including but not limited to treatment notes and narratives, preoperative pictures, x-rays, etc."

15. Thereafter, on or about December 17, 2020, Respondent provided the Board with the information sought pursuant to the December 9, 2020 Subpoena Duces Tecum.

16. On or about February 8, 2021, Respondent was served with a Subpoena Duces Tecum issued by the Board. Pursuant to the Subpoena Duces Tecum, Respondent was commanded to produce and permit inspection and copying of "[t]he complete patient record, including but not limited to treatment notes and narratives, pre- and post-operative pictures, xrays and other imaging, anesthesia records, sedation monitoring records, patient information sheets, appointment information, billings, etc." for A.L., D.V, and J.M.

17. Thereafter, on or about March 8, 2021, Respondent provided the Board with the information sought pursuant to the February 8, 2021 Subpoena Duces Tecum.

18. Upon review of the records received pursuant to the February 8, 2021 Subpoena Duces Tecum, the Board noted that Respondent administered Halcion to A.L. on December 3. 2020, administered anesthesia/nitrous oxide to D.V. on November 30, 2020, and administered nitrous oxide to J.M. to numb, and then ceased and gave Triazolam, on November 24, 2020.

19. On April 15, 2021, Drs. Babak Noorbakhsh and Michael Sokolosky conducted an evaluation and inspection of Respondent and his dental facility. Drs. Noorbakhsh and Sokolosky noted multiple, serious issues in its report that affected public safety, and thus, concluded that Respondent's Class 3B anesthesia permit should be denied.

20. Based on Drs. Noorbakhsh and Sokolosky's evaluation and inspection, by letter dated April 29, 2021 sent via UPS Next Day Air, the Board notified Respondent that his dental facility failed the April 15, 2021 evaluation and inspection. Accordingly, the Board informed

Respondent that given the determination that his permit be denied, Respondent was not authorized to induce the types of sedation and anesthesia set forth in West Virginia Code § 30-4A-3(a) until Respondent and his dental facility could be re-inspected and pass evaluation.

21. To date, Respondent has failed to provide a written response to the Board's complaint.

22. The Board's Complaint Committee reviewed the Board initiated complaint and the medical records and other documents obtained during investigation.

23. Upon recommendation of the Complaint Committee, the Board, by majority vote at its meeting on April 1, 2022, found probable cause to believe that Respondent administered anesthesia without a permit in violation of W. Va. Code §§ 30-1-8(a), 30-4-19(g)(12), (19), 30-4A-1(a), W. Va. Code R. § 5-5-4, and the *American Dental Association Principles of Ethics & Code of Professional Conduct* § 2. Accordingly, the Board determined there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

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24. On or about January 15, 2021, the Board received a Medical Malpractice Payment Report from the National Practitioner Data Bank ("NPDB") concerning a single final payment Respondent agreed to make to a patient of his pursuant to a settlement reached between the patient, T.C., and Respondent. The settlement was reached pursuant to the Medical Professional Liability Act, West Virginia Code § 55-7B-1 et seq. at the early mediation of Civil Action No. 20-C-116 filed in the Circuit Court of Marshall County, West Virginia.

25. On February 10, 2021, Respondent was served with a Subpoena Duces Tecum issued by the Board. Pursuant to the Subpoena Duces Tecum, Respondent was commanded to

produce and permit inspection and copying of "[t]he complete patient record, including but not limited to treatment notes and narratives, pre- and post-operative pictures, x-rays and other imaging, anesthesia records, sedation monitoring records, patient information sheets, appointment information, billings, etc." for T.C.

26. Thereafter, on or about April 22, 2021, Respondent provided the Board with the information sought pursuant to the Subpoena Duces Tecum.

27. By letter dated November 2, 2021, the Board notified Respondent that it initiated a complaint against Respondent and requested that he provide a written response within thirty (30) days. The Board informed Respondent that it was reviewing a malpractice settlement regarding Respondent's treatment of T.C. and potential violations of the Dental Practice Act that may have occurred. Specifically, Respondent was notified: "[y]our treatment of [T.C.] began July 2018 with treatment records through January 2019. Your treatment of this patient consisted of preparation of crown and bridgework, to be used in conjunction with dental implants, extractions, sedation services, TMD and trismus spasms. Multiple breaches of the standard of care appear to have occurred in this matter, as well as possible record keeping violations."

28. To date, Respondent has failed to provide a written response to the Board's complaint.

29. The Board's Complaint Committee reviewed the Board initiated complaint and the medical records and other documents obtained during investigation.

30. Upon recommendation of the Complaint Committee, the Board, by majority vote at its meeting on January 20, 2022, found probable cause to believe that Respondent improperly used light oral sedation for the length of T.C.'s surgery, failed to timely recognize and treat the etiology of the trismus, and improperly inserted implants in T.C.'s mouth, in violation of W. Va.

Code §§ 30-1-8(a), 30-4-19(g)(3), (12), W. Va. Code R. § 5-5-4, and the *American Dental Association Principles of Ethics & Code of Professional Conduct* § 2. Accordingly, the Board determined there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

CONCLUSIONS OF LAW

1. Respondent is a licensee of the Board, holding License No. 2926, and is therefore subject to the license requirements and disciplinary rules of the Board.

2. The Board is a state entity created and governed by W. Va. Code §§ 30-4-1 *et seq.*, and is empowered to regulate the practice of dentistry in the State of West Virginia.

3. In order to carry out its regulatory duties, the Board may suspend, revoke, or otherwise discipline an individual's license to practice dentistry under the authority granted to it by W. Va. Code §§ 30-4-5 and 30-4-19 and W. Va. Code R. §§ 5-1-4, 5-4-1 *et seq.*, and 5-5-1 *et seq.*

4. Respondent does not contest that the Board has probable cause to charge him with one or more violations of the Board's governing statutes and rules based upon its investigation and findings in this matter.

5. The conduct described in the above *Findings of Fact* would, if proven, constitute violations of W. Va. Code § 30-4-19, W. Va. Code R. § 5-5-4, and the *American Dental Association Principles of Ethics & Code of Professional Conduct*. Such conduct is therefore grounds for disciplinary action.

CONSENT OF LICENSEE

I, Charles L. Wylie, DDS, by signing this *Consent Agreement and Order*, acknowledge the following:

1. After having had the opportunity to consult with an attorney of my choice, I sign this Consent Agreement and Order voluntarily, freely, without compulsion or duress, and understand that my signature has legal consequences.

2. The entire agreement is contained in this Consent Agreement and Order, and no person or entity has made any promise or given any inducement whatsoever to encourage me to make this settlement other than as set forth in this document.

3. I am aware that I may pursue this matter through appropriate administrative and/or court proceedings. I am aware of my legal rights regarding this matter, but I have chosen to waive those rights intelligently, knowingly, and voluntarily.

4. I waive any defenses including, but not limited to, laches, statute of limitations, and estoppel, that I may have otherwise claimed as a condition of this agreement.

5. I acknowledge that the execution of this document constitutes disciplinary action by the Board and is therefore considered to be public information.

The Respondent, Charles L. Wylie, DDS, by affixing his signature hereto, agrees to the following Order:

ORDER

Based on the foregoing, and in lieu of further prosecution of these matters, the Board does hereby ORDER and DECREE as follows:

1. Respondent is hereby REPRIMANDED for his actions in these matters.

2. Within sixty (60) days from the date of entry of this Order, Respondent shall pay a fine in the amount of Twelve Thousand Dollars ($12,000.00).

3. Within sixty (60) days from the date of entry of this Order, Respondent shall reimburse the Board the costs of this proceeding in the amount of Seven Thousand Dollars ($7,000.00), including, but not limited to, the administrative and legal expenses incurred by the Board in the investigation and disposition of this case.

4. Respondent shall be restricted from administering any permitted level of sedation procedures in his practice of dentistry until such time as he has applied for and been issued a permit. Respondent may apply for a permit up to a Class 3A and submit to and successfully pass the evaluation and inspection for such permit as set forth in the W. Va. Code §30-4A-1 *et seq.* and the rules of the Board set forth in W. Va. Code R. § 5-12.

5. Respondent shall successfully complete a minimum of twenty (20) hours of professional education in the area of dental implants, which must be pre-approved by the Board. The twenty (20) hours of professional education are in addition to the Board's biennial continuing education requirements for licensed dentists as set forth in W. Va. Code R. § 5-11-3.

6. Respondent shall at all times cooperate with the Board and any of its agents or employees.

7. Respondent shall comply with the West Virginia Dental Practice Act, W. Va. Code §§ 30-4-1 *et seq.*, and the rules and regulations promulgated thereunder.

8. This Consent Agreement and Order shall remain in effect until all of its terms have been completed and the professional education obligations set forth herein have been fulfilled.

9. Any failure to comply with all provisions in this Consent Agreement and Order may result in additional disciplinary action, up to and including the suspension or revocation of Respondent's license to practice dentistry in the State of West Virginia.

10. This document is a public record available for inspection by the public in accordance with the provisions of the West Virginia Freedom of Information Act, W. Va. Code §§ 29B-1-1 *et seq.*, and may be reported to other governmental agencies, professional boards, or other organizations.

11. This Consent Agreement and Order constitutes the entire agreement between the parties.

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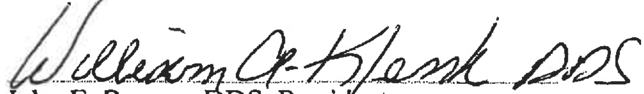
In recognition of this *Consent Agreement and Order*, we hereby affix our signatures.

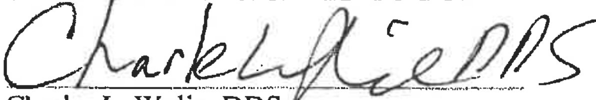
WEST VIRGINIA BOARD OF DENTISTRY

By: 

~~John E. Bogers, DDS, President~~
William A. Klenk, DDS, President

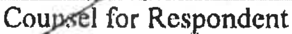
Entered: 7/30/24
Date

REVIEWED AND AGREED TO BY:



Charles L. Wylie, DDS
Respondent

7/19/24
Date



Counsel for Respondent