GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF DENTISTRY

IN RE:	:
EDWARD LONGWE, DDS	:
License No.: DEN1000625	:
Respondent	:

FINAL ORDER AND DECISION

Jurisdiction

This matter comes before the District of Columbia Board of Dentistry (the "Board") pursuant to D.C. Official Code § 3-1201.01 *ff.* (2012 Repl.), otherwise known as the Health Occupations Revision Act (the "HORA"). The HORA, at D.C. Official Code § 3-1202.01(b) (2012 Repl.), authorizes the D.C. Board to regulate the practice of Dentistry in the District of Columbia.

Background

On or about January 6, 2017, the Board issued a Notice of Intent to Take Disciplinary Action (the "Notice") against Respondent's District of Columbia Dental license. The Notice charged Respondent as follows:

> **You were disciplined by the Virginia Board of Dentistry (Virginia Board) for conduct that would be grounds for disciplinary action under D.C. Official Code § 3-1205.14 (a)(26)[1] and (28)[2], for which the Board may take action under D.C. Official Code § 3-1205.14(a)(3) (2012 Repl).**

---

[1] (a)(26) Fails to conform to standards of acceptable conduct and prevailing practice within a health profession.

[2] (a)(28) Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, regardless of whether the patient sustains actual injury as a result.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF DENTISTRY

IN RE:	:
EDWARD LONGWE, DDS	:
License No.: DEN1000625	:
Respondent	:

FINAL ORDER AND DECISION

Jurisdiction

This matter comes before the District of Columbia Board of Dentistry (the "Board") pursuant to D.C. Official Code § 3-1201.01 *ff.* (2012 Repl.), otherwise known as the Health Occupations Revision Act (the "HORA"). The HORA, at D.C. Official Code § 3-1202.01(b) (2012 Repl.), authorizes the D.C. Board to regulate the practice of Dentistry in the District of Columbia.

Background

On or about January 6, 2017, the Board issued a Notice of Intent to Take Disciplinary Action (the "Notice") against Respondent's District of Columbia Dental license. The Notice charged Respondent as follows:

> **You were disciplined by the Virginia Board of Dentistry (Virginia Board) for conduct that would be grounds for disciplinary action under D.C. Official Code § 3-1205.14 (a)(26)[1] and (28)[2], for which the Board may take action under D.C. Official Code § 3-1205.14(a)(3) (2012 Repl).**

---

[1] (a)(26) Fails to conform to standards of acceptable conduct and prevailing practice within a health profession.

[2] (a)(28) Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, regardless of whether the patient sustains actual injury as a result.

Pursuant to Title 17 DCMR §§ 4105.1 and 4105.2(c), the Notice was served by U.S. Postal Service Certified Mail, return receipt requested, on the Respondent's Counsel. According to post office tracking records, the Notice was delivered to the Respondent's Counsel on January 12, 2017. The Notice advised Respondent that he had twenty (20) days following receipt of the Notice in which to request a hearing. The Respondent, through counsel, submitted a timely request for a hearing upon receipt of the Notice.

The hearing was held before the Board on May 17, 2017[3]. Assistant Attorney General, Pete Chattrabhuti, Esq., and Assistant Attorney General, Amy Schmidt represented the Government. Mr. Marc Brown, Esq. represented the Respondent.

Evidence

The Board introduced one (1) exhibit which was marked and admitted into evidence: Board Exhibit No. 1 (BX#1)- The Notice of Intent to Take Disciplinary Action against Respondent (Tr. 05/17/17- P. 7: 12-22; P. 8: 1-22; P. 9: 1-20).

The Government introduced two (2) exhibits which were marked and admitted into evidence: Government Exhibit No. 1 (GX#1)- The Virginia Board of Dentistry consent order entered November 20, 2016 (Tr. P. 31, Ln. 13-22; P. 32, Ln. 1-7) (the "Virginia Consent Order"); Government Exhibit No. 2 (GX#2)- Notice of summary action to suspend license issued by the District of Columbia Department of Health, Board of Dentistry (Tr. 05/17/17- P. 32, Ln. 9-22; P. 33, Ln. 1-2).

[3] The Board members present and holding the hearing on this date consisted of John Baily, DDS (presiding board member), Judith Henry, DDS, MPH, Iris Jeffries-Morton, DDS, and Dianne Smith, Esq., Consumer Board member. Carla M. Williams, Esq., Assistant General Counsel served as legal counsel to the Board. Pursuant to D.C. Official Code § 3-1204.05(c), the four (4) members present constituted a quorum of the Board and were sufficient to conduct the hearing.

The Respondent introduced five (5) exhibits. The Respondent's Exhibits 1, 3, 4 and 4b were admitted into evidence. The Respondent's Exhibit No. 2 was not admitted.

Respondent's Exhibit No. 1 (RX#1)- Edward Longwe's Resume (Tr. 05/17/17- P. 36, Ln. 7-22; P. 37, Ln. 1-4); Respondent Exhibit No. 2- (not admitted)[4]; Respondent Exhibit No. 3 (RX#3)- Respondent's Office Chart/Anesthesia Record (Tr. 05/17/17- P. 61, Ln. 14-22; P. 66, Ln. 1-7); Respondent Exhibit No. 4 and No. 4b (RX#4) and (RX#4B) – Hospital Radiology Reports (Tr. 05/17/17- P. 61, Ln. 14-22; P. 66, Ln. 1-7).

The witnesses for the Respondent were Robert Jones, DDS, a former colleague of the Respondent[5], and the Respondent who testified on his own behalf. The Government did not call any witnesses.

As a preliminary matter, the Respondent, through counsel, stipulated that the Respondent was disciplined by another jurisdiction's licensing board, and that the basis of the discipline would be grounds for discipline in the District of Columbia as charged in the Notice. (Tr. 05/17/17- P. 16-24). Based upon this stipulation, the parties agreed that the Government's burden had been met and that the remainder of the proceeding would only go towards the sanction. With that stipulation and agreement of the parties, the Board allowed the Respondent to testify regarding the underlying facts to shed further light on this incident solely for the purposes of determining the appropriate sanction to be imposed. (Tr. 05/17/17- P. 20-24).

[4] Continuing Dental Education Seminar on Anesthesiology[4] (Tr. 05/17/17- P. 61, Ln. 4-12; P. 62, Ln. 10-22; P. 63, Ln. 1-22; P. 64, Ln. 1-22; P. 65, Ln. 1-9).

[5] Dr. Jones was presented as a character witness only. He had no knowledge of the facts surrounding this incident.

Findings of Fact

Based upon the testimony of the witnesses, the Board's evaluation of the witnesses' credibility, the admitted documentary evidence, and the entire record of these proceedings, the Board hereby makes the following findings of fact and conclusions of law:

1. At all times relevant, the Respondent was licensed to practice Dentistry in the District of Columbia as a dentist.

2. Respondent was issued License Number 0401-411847 on June 13, 2007, to practice dentistry in Virginia. (GX#1 at pg. 2.)

3. Respondent was issued Registration number 0438-000264 on May 26, 2009 to perform oral and maxillofacial surgery in Virginia. (GX#1 at pg. 2.)

4. On or about August 5, 2016, the Virginia Board of Dentistry summarily suspended the Respondent's Virginia dental license upon the finding that his continued practice constituted a substantial danger to public health or safety. (GX#1 at pg. 2).

5. On or about November 30, 2016, Respondent entered a Consent Order Agreement with the Virginia Board of Dentistry wherein Respondent's license to practice dentistry in Virginia was revoked. (GX#1)

6. The consent order pertained to Respondent's administration of anesthesia on March 4, 2016 to Patient A, a four and a half (4 ½) year old male, and Patient A's subsequent death on March 5, 2016, and the Respondent's handling of the matter. GX#1.

7. On December 7, 2016, the District of Columbia Department of Health summarily suspended the Respondent's District of Columbia dental license based upon the revocation of his Virginia dental license. (GX#2.)

8. The Findings of Fact and Conclusions of Law made by the Virginia Board as part of the Virginia Consent Order are hereby adopted and incorporated by reference in their entirety. (GX#1)

Conclusions of Law

D.C. Official Code § 3-1205.14 (2001) provides in pertinent part:

(a) Each board, subject to the right of a hearing as provided by this subchapter, on an affirmative vote of a majority of its members then serving, may take one (1) or more of the disciplinary actions provided in subsection (c) of this section against any applicant, licensee, or person permitted by this subchapter to practice the health occupation regulated by the board in the District who:

(3) Is disciplined by a licensing or disciplinary authority or peer review body or convicted or disciplined by a court of any jurisdiction for conduct that would be grounds for disciplinary action under this section;

(26) Fails to conform to standards of acceptable conduct and prevailing practice within a health profession; and

(28) Demonstrates a willful or careless disregard for the health, welfare, and safety of a patient, regardless of whether the patient sustains actual injury as a result;

(c) Upon determination by the board that an applicant, licensee, or person permitted by this subchapter to practice in the District has committed any of the acts described in subsection (a) of this section, the board may:

(1) Deny a license to any applicant;

(2) Revoke or suspend the license of any licensee;

(3) Revoke or suspend the privilege to practice in the District of any person permitted by this subchapter to practice in the District;

(4) Reprimand any licensee or person permitted by this subchapter to practice in the District;

(5) Impose a civil fine not to exceed $5,000 for each violation by any applicant, licensee, or person permitted by this subchapter to practice in the District;

(6) Require a course of remediation, approved by the board, which may include:

(A) Therapy or treatment;

(B) Retraining; and

(C) Reexamination, in the discretion of and in the manner prescribed by the board, after the completion of the course of remediation;

(7) Require a period of probation; or

(8) Issue a cease and desist order pursuant to § 3-1205.16.

Title 17 DCMR § 4115.1 provides:

> "In a hearing resulting from a proposed disciplinary action taken under DCMR § 17-4102.1, the District shall have the burden of proving by a preponderance of the evidence that the action should be taken."

Charge: **Disciplined by a licensing or disciplinary authority for conduct that would be grounds for disciplinary action in the District of Columbia.**

As previously discussed, Respondent stipulated that based upon the consent order he entered into with the Virginia Board of Dentistry, he has been disciplined by a licensing or disciplinary authority for conduct that would be grounds for disciplinary action in the District of Columbia as charged in the Notice, and that the government's burden in this case has been met. Therefore, the Board finds by a preponderance of the evidence and concludes as a matter of law that the Respondent was disciplined by the Virginia Board of Dentistry for conduct that would be grounds for disciplinary action under D.C. Official Code § 3-1205.04(a)(26)(2012 Repl.) (Failing to conform to standards of acceptable conduct and prevailing practice); and that would be grounds for disciplinary action under D.C. Official Code § 3-1205.14(a)(28) (2012 Repl.) (Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient) for which the Board may take action pursuant to D.C. Official Code § 3-1205.14(a)(3)(2012 Repl.).

Decision

The parties agreed that based upon the Respondent's stipulation, the hearing in this matter would be for the limited purpose of enabling the Board to determine the appropriate sanction to impose.

In a case in which the Respondent is charged with having been disciplined by a licensing or disciplinary board, the government is not required to prove that the Respondent committed the underlying conduct. Therefore, the Respondent is not permitted to dispute the findings of fact and conclusions of law set forth in the other board's order or consent order, which formed the basis of the Respondent's discipline by the other state board. It is well-established law that reciprocal discipline proceedings are not a forum to reargue the foreign discipline. See, *In re Zdravkovich, 831 A.2d 964, 969 (D.C.2003).* To be clear, a Respondent may litigate whether the conduct described in a finding of fact would constitute a violation of the District of Columbia's laws or regulations. However, the Respondent may not litigate whether the conduct described in the finding of fact occurred.

In the case at bar, because the Respondent stipulated to the violation, the Board agreed to allow him to present evidence and testimony to shed further light on the details surrounding this incident for the limited purpose of arguing as to the appropriate sanction that should be imposed. (Tr. 5/17/17- P. 22-24). The purpose of this opportunity was not to allow the Respondent to deny that the conduct described in the finding of facts occurred. It was to allow the Respondent to give his perspective and help the Board to better understand why it occurred.

The Respondent admits that he signed the Virginia Consent Order which states, "I admit to the Findings of Fact and Conclusions of Law contained herein and waive my right to contest such Findings of Fact and Conclusions of Law and any sanction imposed herein in any future judicial or administrative proceeding in which the Board is a party;" (GX#1 at pg. 7). However, he testified during the course of the hearing that he disputed nearly all of the Findings of Fact and Conclusions of Law in the Virginia Consent Order. (Tr. 5/17/17- P. 44, Ln. 11-16; P. 47, Ln. 17-22; P. 48-50.)

The Respondent testified that he signed the Virginia Consent Order even though he disagreed with the Findings of Fact and Conclusions of Law, because he felt pressured to do so. He stated that the attorneys who represented him in that matter told him that he had to either come up with $55,000.00, so that the case could go to a hearing, or sign the Virginia Consent Order. He stated that this was the only choice his attorneys gave him. (Tr. 5/17/17- P. 43, Ln. 7-21; P. 44, Ln. 1). He further stated that he was only given a few days to sign it and was told that if he didn't he would be severely punished and his license would be completely ruined. (Tr. 5/17/17- P. 46, Ln. 17-22; P. 47, Ln. 1). The Board makes no finding on the credibility of the Respondent's testimony regarding this issue, because it is irrelevant and moot. The Respondent signed the Virginia Consent Order and in doing so he admitted to the Findings of Fact and Conclusions of Law contained in the Virginia Consent Order. Moreover, he waived his right to contest those Findings of Fact and Conclusions of Law. (GX#1 at pg. 7.) If he now contends that he signed a consent order admitting to findings of fact and conclusions of law that were not true because the attorneys assigned by his malpractice insurance carrier told him to, that is a matter between him, his former attorneys, and his malpractice insurance carrier. However, it is not an issue for this Board.

As previously discussed, reciprocal discipline proceedings are not a forum to re-litigate the facts. To be clear, the Board has adopted the Findings of Fact and Conclusions of Law as set forth in the Virginia Consent Order in toto. Therefore, to the extent that the Respondent completely denies the truth of the Findings of Fact and Conclusions of Law that he admitted to in the Virginia Consent Order, the Board does not give any weight to or credit his testimony.[6] Throughout the course of the hearing, the Respondent repeatedly, completely denied the truth of

[6] The Respondent stated that he disagrees with the following findings of fact set forth in the Virginia Consent Order: #3a, #3b, #3c, #5a, #5b, #5c, #5d, #5e, #5g, #5h, #6a, #6b, #6c, #6d, #6e, #7a, #7b, #7c, #7d, #7e, #7f, #7g, and #8.

the Findings of Fact and Conclusions of Law in the Virginia Consent Order rather than provide additional information and details to shed light on the circumstances surrounding incident. Inasmuch as the Board does not credit the Respondent's testimony which seeks to completely deny the conduct set forth in the Findings of Facts and Conclusions of Law in the Virginia Consent Order, the Board will not consider his testimony regarding those findings. The Board will instead focus its review on the Findings of Fact and Conclusions of Law that the Respondent testified he agreed to, and those to which he provided clarification and additional information as opposed to a complete denial.

The Respondent testified that he was asked to provide general anesthesia to Patient A, by Dr. Armakan, who is a pediatric dentist. (Tr. 5/17/17- P. 38, Ln. 2-4). The Respondent testified that he is not an anesthesiologist. (Tr. 5/17/17- P. 39, Ln. 19-22). The Respondent testified that since 2010, he had administered anesthesia to close to one hundred and fifty (150) children prior to Patient A. (Tr. 5/17/17- P. 40, Ln. 17-22; P. 41, Ln. 1-5). The Respondent admitted that he is not Board certified, but stated that he is in the process. (Tr. 5/17/17- P. 41, Ln. 6-8).

Though the Respondent disputes nearly all of the Findings of Fact and Conclusions of Law in the Virginia Consent Order, he testified that he did agree with the timeline regarding when 911 was called to initiate EMS to come and transport the patient for advanced medical care. (Tr. 5/17/17- P. 51, Ln. 21-22; P. 52, Ln. 1-2). Finding of Fact #5 of the Virginia Consent Order contains the 911 timeline. (GX #1 at pg. 3-5).

Finding of Fact #5a states, "Between approximately 1215 and 1220 hours, after Dr. Longwe administered general anesthesia to Patient A, he began to experience hypoxemia and bradycardia. Dr. Longwe failed to order a staff member to call 911 immediately in response to this emergency." (GX#1 at pg. 3). Respondent testified that when the emergency was noted, he immediately secured the patient's airway, intubated the patient, and ventilated the patient. (Tr.

5/17/17- P. 52, Ln. 5-15). The Respondent further testified that, "[W]hen bradycardia was noted, compressions were done. And by the time we applied the pads, the AED pads, the patient had returned to normal sinus rhythm, but the – when the AED instructed that continue CPR, CPR was continued for protection, but there was no further bradycardia since that time." [sic] (Tr. 5/17/17- P. 52, Ln. 16-22).

Regarding the delay in calling 911, Respondent testified, "[B]ecause all the vital signs returned to normal, including CO2, blood pressure, I felt that the patient is going to wake up, and that was the delay of calling 911 to assist us in transporting the patient for advanced medical care because the patient was under anesthesia which was an induced state of the patient that we put in for the procedure. So my position was that the patient had a delayed awakening from anesthesia, not that something else may have gone wrong as such." (Tr. 5/17/17- P. 53, Ln. 1-11).

Despite initially stating that he agreed with the 911 timeline, the Respondent subsequently testified that he denied that EMS was not contacted until two and a half (2 ½) hours after Patient A first began to experience complications. (Tr. 5/17/17- P. 55, Ln. 17-22; 1-20; P. 57, Ln. 2-8). Finding of Fact #5f of the Virginia Consent Order states, however, "[R]ecords and a recording from Loudoun County Fire, Rescue, & Emergency Management ("EMS") indicate that they were not contacted by Dr. Longwe until 1453 hours, approximately two and one-half (2 ½) hours after Patient A first began to experience complications." (GX#1 at pg. 4). The Board noted then when the Respondent was asked to list all of the findings of fact that he now contends are not correct, Finding of Fact #5f was not included in his list.

Finding of Fact #5d states, "Dr. Longwe disregarded multiple requests by others in the procedure room to contact 911 after Patient A began to experience hypoxemia and bradycardia. After resuscitation, Patient A remained unconscious, unresponsive, and in a critical emergency state. Dr. Longwe insisted that unresponsiveness was due to slow recovery from the sedation

medications, and continued to delay in contacting 911." (GX#1 at pg. 4). The Respondent listed Finding of Fact #5d as being among those that he disputed. However, during his testimony, the Respondent admitted that, "[A]t about 12:45, I believe it was mentioned that should we call 911? And I said, let's establish airway, because I need to make sure that the patient's airway is secured. And that was the mention of 911." (Tr. 5/17/17- P. 80, Ln. 1-17).

In response to questioning by the Board as to why he didn't call 911 while he still continued his efforts to wake the child knowing that the time to revive the patient was critical, the Respondent stated, "Well, it was not like I did not do anything about it." (Tr. 5/17/17- P. 81, Ln. 7-12). The Respondent then reiterated his account of the steps he took to establish and manage the patient's airway. He further stated, "[I]t is not unusual to have some delayed awakening from anesthesia from a patient." (Tr. 5/17/17- P. 81, Ln. 7-19). He further stated, "[M]y thought was that this could be a non-metabolism of medication in his system, and that is what me made me feel that let's not rush, because the vital signs are normal. I expect the patient to wake up." [sic] (Tr. 5/17/17- P. 82, Ln. 5-9). When pressed further as to why he decided to delay calling EMS as opposed to calling them while he continued his efforts to wake the child, the Respondent stated, "Well, it is something that I regret today, that probably I should have called 911." (Tr. 5/17/17- P.84, Ln. 2-4). However, he then went on to state that he did not believe that the patient received excessive medication. He stated that, "something went wrong with the patient." (Tr. 5/17/17- P. 83, Ln. 14-22; P. 84, Ln. 1-8). The Respondent admitted, however, that he had not previously used the combination of drugs on a four and a half (4 ½) year old patient that he used on Patient A. (Tr. 5/17/17- P. 77, Ln. 5-14).

The Board questioned the Respondent regarding the fact that the Respondent's anesthesia record, RX #3, did not state the amount of lidocaine administered to Patient A. The Respondent replied that Dr. Armakan gave Patient A the lidocaine, and did not document the amount, and

therefore the Respondent did not know the amount that was administered. (Tr. 5/17/17- P. 73, Ln. 6-22; P. 74-75; P. 76, Ln. 1-3). The Respondent testified, however, that the general anesthesia was administered first. (Tr. 5/5/17- P 75, Ln. 16-17).

The Respondent testified that the anesthesia record included in RX#3 showed that he was monitoring Patient A in five (5) minute increments and not fifteen (15) minute increments as set forth in Finding of Fact #6c of the Virginia Consent Order. (Tr. 5/17/17- P. 97, Ln. 9-22; P. 98, Ln. 1-10). However, as previously discussed, the Board will not credit the Respondent's testimony which seeks to completely deny findings of fact that he previously admitted to when he signed the Virginia Board's Consent Order. Furthermore, even if the Respondent's testimony was not a complete contradiction of the established Finding of Fact set forth in #6c, the Board would still question the authenticity of the anesthesia record document submitted by the Respondent. The Respondent testified that he gave a copy of the anesthesia record to the Virginia Board investigator and explained the document to the board investigator. However, Findings of Fact #6c and #7c of the Virginia Consent Order state that the respondent failed to monitor the patient in five (5) minute increments. (GX #1 at pg. 6). Moreover, the Respondent testified that he personally completed the entire document, including the five (5) minute increments of monitoring. (Tr. 5/15/17- P. 99, Ln. 5-22; P. 100, Ln. 1-22; P. 101, Ln. 1-2). However, the Board finds that it is highly improbable that the Respondent could have performed this monitoring and documentation while administering and directing the efforts to establish and manage the patient's airway. Moreover, the Respondent testified that the five (5) increment notes were taken from the electronic medical record which records all of the vital signs and integrates them into the computer automatically. The Board attempted to gain a clearer understanding from the Respondent as to whether it was his testimony that he personally checked the patient's vitals and documented the record in five (5) minute increments or whether he

populated the document using the information he retrieved from the electronic medical record. His responses were inconsistent and contradictory. (Tr. 5/17/17 P. 115, Ln. 20-22; 116-118; P. 119, Ln. 1-7). For these reasons, and because the record is contradicted by the findings of fact in the Virginia Consent Order, the Board does not find Respondent's RX#3 credible and does not give it any weight.

The Respondent further testified that when Patient A did not wake up after receiving two doses of a reversal agent, Flumazenil, he first went and spoke to the Patient's father and told him what was going on before he called 911. He testified that approximately 10-15 minutes passed from the time he administered the first dose of Flumazenil until he called 911. (Tr. 5/17/17- P.77, Ln. 20-22; P. 78, Ln. 1-18).

The Respondent testified that he later learned from the physician at [Inova] Fairfax Hospital that there was something in the radiology report consistent with aspiration. (Tr. 5/17/17- P. 84, Ln. 9-22; P. 85, Ln. 1-3). He stated that he was focused on anesthesia versus "another event that happened to the patient such as vomit that I did not notice, and therefore, when I ventilated the patient, the patient was compromised with the vomit. But of course I could not prove it." (Tr. 5/17/17- P. 85, Ln. 4-10). He stated, "So certainly, if I look back, I would say probably I should have called 911. But the events of additional things that the hospital found is certainly beyond my care, because I verified initially that this patient had nothing to eat for at least 12 hours, and I went by that, and I was not looking for the vomit." (Tr. 5/17/17- P. 85, Ln. 15-21).

Though the Respondent speculates that the patient's death was caused by vomit, and attempts to assign blame to the patient's parent for stating that the patient had not eaten for at least 12 hours, the Findings of Fact in the Virginia Consent Order do not support the Respondent's claim. Finding of Fact #5i states, "The Board-certified Pediatric Critical Care

specialist who treated Patient A immediately prior to his death indicated that Patient A died from a hypoxic brain injury and heart failure. This specialist also opined that it was likely that the patient lost his airway early in the procedure and no one noticed." (GX #1 at pg. 5).

Regarding the informed consent document which stated that the anesthesia would be administered by an anesthesiologist or certified registered nurse anesthetist credentialed by INOVA Health System, the Respondent testified that, "It was a mix-up of the forms that I had in the office, and I did not pay attention to the word...that says INOVA." (Tr. 5/17/17- P.47, Ln. 12-15). The Respondent stated that he personally gave the consent form to the patient's guardian. (Tr. 5/17/17- P.47, Ln. 15-16).

The Respondent testified, "[T]he consent for medical anesthesiologists is no different from what we utilize because the medication are not different from it." [sic] (Tr. 5/17/17- P. 125, Ln. 1-4). He further stated, "You have to explain to the patient what exactly you're going to do because a layperson is not a trained dentist or medical profession that would just understand it. And, therefore, I did explain to the patient—to the guardian what is going to happen and what are the possible favorable or adverse reaction to anesthesia that the guardian understood." [sic] (Tr. 5/17/17- P. 125, Ln. 10-18). He further stated, "So, to suggest it's complex, yes, it is complex. But, none of the consent forms are just layman's terms. You have to explain to the guardian." (Tr. 5/17/17- P. 125, Ln. 19-22). He further testified, "Regarding the form that was drafted by Fairfax Anesthesiologists, I explained the area that it was a mix up of papers that were together, the consent forms that I brought to the patient the wrong one. I didn't check the name on it...that's why it is like that. But, it was not intention to---I just deliberately used that." [sic] (Tr. 5/17/17- P. 126, Ln. 1-9).

In formulating its decision as to the appropriate sanction to impose, the Board took into consideration the nature of the charge and the Board's paramount duty to protect the public.

Although there are few greater tragedies than the death of a child, the Board does not take the position that even the death of a child must result in an automatic revocation of licensure. The Board is aware that adverse results can sometimes occur under circumstances in which the practitioner is not at fault and could have done nothing to prevent the result. However, in the case at bar, the Board does not find that the Respondent is without fault for the circumstances leading to Patient A's death, or that he could not have undertaken actions to prevent this loss of life.

The Board finds that the Respondent committed a host of errors in bad judgment and poor decision-making which greatly increased the likelihood of Patient A's death. The Findings of Fact and Conclusions of Law in the Virginia Board's Consent Order included:

- The Respondent failed to perform or document an evaluation of Patient A's airway prior to the administration of anesthesia. (#3a)
- The Respondent administered anesthesia that was excessive for Patient A's weight considering the other central nervous system depressant agents that were also used. (#3b)
- After the patient began to experience hypoxemia and bradycardia, the Respondent failed to call 911 for another two and one-half (2½) hours. (#5a, #5d, #5f)
- The Respondent did not administer a reversal agent until 1330 and 1335 hours. (#5e)[7]
- The responding Emergency Medical Technician discovered upon arriving in Patient A's procedure room that there was no etCO2[8] reading on the capnography monitor that the Respondent was using. The Respondent was unable to tell the EMT the patient's etCo2 reading. The EMT determined that Patient A's initial etCO2 reading was at least 100mmHg, indicating that the patient was not being ventilated, manually or mechanically. (#5g)

[7] This was forty-five (45) and fifty (50) minutes after the Respondent first became aware that the patient was having complications and not waking up.

[8] The end-tidal carbon dioxide (CO2).

- The Respondent failed to monitor Patient A's etCO2 adequately from the time of intubation until the arrival of EMS, which was a period of approximately two and one-half (2 ½) hours. (#5g)

- The Respondent did not have available, or did not correctly utilize, an etCo2 monitor. (#6b)

- The Respondent failed to continue monitoring Patient A's vital signs through the preoperative, sedation, and recovery period, until the patient's care was transferred to the emergency medical technicians. (#6d)

- After the patient was transported to the hospital, and subsequently to a Level I trauma center, the Respondent failed to be forthcoming with complete and accurate, time-sensitive, clinical information about the course of Patient A's treatment and condition while at his office. The information he provided led subsequent treatment providers to mistakenly believe that EMS was contacted soon after Patient A began to experience complications. Further he failed to document or inform subsequent treatment providers of the amount of time that chest compressions were performed on Patient A, critical information when determining how to manage Patient A's care. (#5h)

The Board finds wholly unacceptable the Respondent's stated reasoning for failing to call 911 for approximately two and one-half (2 ½) hours after the patient first began experiencing complications. The Respondent repeatedly stated that he expected the patient to wake up, even when the child showed absolutely no signs of waking up or regaining consciousness. Based upon his testimony and overall demeanor, it appears to the Board that there was no point in time during this incident when the Respondent appropriately recognized the gravelly serious and critical nature of the situation. The Respondent even testified that when he finally acknowledged that it was time to call 911, he first left the procedure room and went to the waiting room and explained to the patient's father what was going on before he then returned to the procedure room and called 911. The Board is absolutely dumbfounded that the Respondent would take the time to go and discuss the situation with the child's father before initiating the emergency call to 911 when he knew or should have known that when dealing with critical life or death matters,

every second counts. The Respondent even testified that it was his thought, "let's not rush, because the vital signs are normal." [sic] (Tr. 5/17/17- P. 82, L. 6-7).

The Board finds that the Respondent did not err on the side of doing what was in the best interests of this child. Particularly striking, he testified that, "So from that time, when the AED analyze it, the patient again, it says continue CPR, but the vitals remained normal, no drop of vital signs, so I asked them to stop giving CPR. And we monitored the patient from that time and waited for – for the patient to wake up. The patient was not waking up, but all the vitals remained normal." (Tr. 5/17/17- P. 95, Ln. 22; P. 96, Ln. 1-7). The Respondent in essence testified that even though the AED instructed them to continue CPR, he ceased CPR because the vitals were normal.

Further, the Respondent testified that he monitored all of the patient's vital signs including the capnography or end-tidal CO2. (Tr. 5/15/17- P. 88, Ln. 13-21). However, Finding of Fact #5g of the Virginia Consent Order states that when the EMT arrived "he discovered there was no etCO2 reading on the capnography monitor being used by Dr. Longwe, and when asked, Dr. Longwe responded that he did not know the etCO2 reading for Patient A." (GX #1 at pg. 4).

Dr. Longwe testified that his anesthesia record documents that he charted the patient's CO2 numerical values. (Tr. 5/15/17- P. 45, Ln. 4-10). However, if he had been charting the numerical values as he claims on the document he now presents to the Board, he would have been able to answer the EMT's question. Further, Finding of Fact #5g of the Virginia Consent Order states, "The EMT determined that Patient A's initial etCO2 reading was at least 100mmhg (normal 35mmHg-45mmHg), indicating that Patient A was not being ventilated, manually or mechanically." (GX#1 at pg. 4-5). The Board notes that the Respondent's anesthesia record, RX #3, lists the patient's etCO2 numerical values as ranging from 39-45, which further calls into

question the authenticity of the document, which the Board has already determined that it does not find to be credible.

If the Respondent had been monitoring the patient's etCO2 as he now claims, he would have known the patient's reading and he would have known from the high level of the reading that the patient was not receiving the ventilation he needed. Instead, as stated in Finding of Fact #6b, the Respondent did not have available, or did not correctly utilize, an etCO2 monitor. The Board finds that this failure is why the Respondent did not know that the patient was not being properly ventilated as he waited for him to wake up instead of calling 911.

Also disturbing to this Board is the Respondent's apparent belief that if the child vomited and this contributed to his death, that this somehow relieves the Respondent of blame. The Respondent stated, "Well, that certainly got me concerned that what I was dealing with was beyond anesthesia care that I have been trained to do, and that the –I have known during my training and through regular patient care that a patient should not have any food in their stomach during –when they anticipate to be under general anesthesia…" [sic] (Tr. 5/17/17- P. 105, Ln. 6-13). Likewise, he testified, "But the events of additional things that the hospital found is certainly beyond my care, because I verified initially that this patient had nothing to eat for at least 12 hours, and I went by that, and I was not looking for vomit." (Tr. 5/17/17- P. 85, Ln. 16-21).

Even if the patient's father told the Respondent that the patient did not have anything to eat in the twelve (12) hours prior to the procedure, once the patient began experiencing complications, the Respondent had a duty to evaluate all possible causes. The Board finds that for the Respondent to simply say, well I didn't look for vomit because he told me the child had not eaten, is insufficient and inexcusable. Moreover, the Board finds that the Respondent's testimony calls into question whether he was properly trained and qualified to perform the level

of anesthesia that he administered to Patient A, because a practitioner must be trained and qualified to both sedate ***and to recover*** a patient from anesthesia.

The Board must act to ensure that the District's citizens are safe from health professionals who fail to appropriately conform to standards of acceptable conduct and prevailing practices within the health profession, or who demonstrate a willful or careless disregard for the health, welfare, and safety of their patients.

The Respondent asserts that he has received an offer to serve on the faculty at Howard University's School of Dentistry. As such, he asks that this Board allow him to maintain licensure but that it be limited to teaching. In support of this request, the Respondent offered character testimony from his former college, Robert Jones, DDS. Dr. Jones testified that he has known the Respondent, initially as a resident, and subsequently as a colleague, academically, at Howard University. (Tr. 5/17/17- P. 129, Ln. 18-20). Dr. Jones testified very favorably regarding the Respondent's knowledge of oral and maxillofacial surgery. He stated, "Dr. Longwe is, by any measure, a competent oral and maxillofacial surgeon. And, that's evaluated through his knowledge, his experience and his education." (Tr. 5/17/17- P.130, Ln. 3-10). He further testified that he has observed Dr. Longwe clinically as well as academically and, "I have been very impressed in that Dr. Longwe's exhibited competence at all levels, even at the highest level of all of the aspects of academic oral and maxillofacial surgery as well as clinical oral and maxillofacial surgery." (Tr. 5/17/17- P. 130, Ln. 14-22; P. 131, Ln. 1-4). He further testified that he has had discussions with the administration at Howard University about potentially hiring the Respondent to teach. He stated that the conversations had been met with enthusiasm, but with some reservation on the part of the credentials office because of his licensure status. He stated that barring that, there was complete support and enthusiasm for bringing him back. (Tr.

5/17/17- P. 132, Ln. 12-22; P. 133, Ln. 1-8). Dr. Jones testified that he has not personally observed the Respondent's practice since 2014-2015. (Tr. 5/17/17- P. 134, Ln. 16-21).

As discussed in his closing, the Respondent seeks of this Board a license that will allow him to teach, or to practice but not administer anesthesia, or a chance to take additional coursework to address any of the Board's concerns. However, as previously stated, the Board has a duty to protect the public. While the Respondent may view this as an isolated event in the course of his twenty (20) year career, the Board is concerned by the numerous and egregious lapses in sound clinical judgment that the Respondent displayed throughout the duration of this incident.

Moreover, as correctly characterized by the Government in its closing, the Respondent did not accept responsibility for his actions that took place that day. The Respondent's testimony to this Board blamed his lawyers, Dr. Armakan, the medical equipment in his office, the Virginia Board of Dentistry, the consultant used by the Virginia Board of Dentistry, and the patient's father for seemingly failing to disclose what he believes is that the patient had eaten within the 12 hours prior to the procedure. If the Respondent still does not fully recognize, appreciate, and take ownership of his part in what happened to this child, how can the Board be assured that he does not continue to pose a threat to the citizens of the District of Columbia?

The Respondent was in charge of the anesthesia for that procedure. It was his duty to know every substance that was introduced into that patient's body. It was inexcusable for him to not know how much local anesthesia Dr. Armakan administered and if Dr. Armakan failed to document it, it was the Respondent's duty to obtain that information from Dr. Armakan during the course of the procedure, especially once the child began experiencing complications. Instead, the Respondent testified that though he didn't know how much lidocaine Dr. Armakan

had given the patient, and though he had never administered this combination of drugs to a four (4) year old before, he still does not believe that the child was over-medicated.

Further, the Board is left speechless by his statement that it never occurred to him to look for vomit because he asked the parent if the child had eaten anything within the 12 hours before he started the procedure. Though the Virginia Findings of Fact do not support the Respondent's contention that vomit contributed to Patient A's death, the Board yet finds that when the Respondent realized that he had a four and a half (4 ½) year old patient that was having complications, and who was not waking up, he should have considered all possible causes. Moreover, he can assign blame to no one but himself for repeatedly making the decision to delay calling 911 for two and one-half (2 ½) hours, because he believed that despite all appearances to the contrary the child would wake up.

The Board is wholly unsatisfied by his explanations and finds that he is not fit to practice dentistry in the District of Columbia at this time. Further, the Board finds that he is not fit to train and shape the minds of future dental practitioners in the District of Columbia at this time. Additionally, the Respondent's request to teach fails to acknowledge that the Oral and Maxillofacial program is not a didactic program. It is in the clinic. As such, teaching would require him to be on the clinic floor working with the interns and patients, and he would necessarily have to be involved in the patients' clinical care. Moreover, if an adverse event occurred, he would have to respond and provide the necessary clinical intervention. For the reasons discussed above, the Board does not find that the Respondent can be entrusted with this responsibility at this time, and finds that it is not in the best interests of the public that he be granted a license of any type at this time.

ORDER

Based upon the aforementioned it is hereby **ORDERED** that the District of Columbia Dentistry license issued to Edward Longwe, License No. DEN1000625, shall be and is hereby SUSPENDED, for not less than three (3) years effective as of the date of service of this Order; and it is further

ORDERED that his license shall remain suspended until he submits proof to this Board that his Virginia dental license has been reinstated and is in good standing.

December 20, 2017
Date

John Bailey, DDS
Presiding Board Member
District of Columbia
Board of Dentistry

Judicial and Administrative Review of Actions of Board

Pursuant to D.C. Official Code § 3-1205.20 (2001):

> Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the **District of Columbia Court of Appeals** pursuant to D.C. Official Code § 2-510 (2001).

Pursuant to D.C. Court of Appeals Rule 15(a):

> Review of orders and decision of an agency shall be obtained by filing with the clerk of this court a petition for review within thirty (30) days after the notice is given.

This Order is the Final Order of the Board in this disciplinary matter and a public record and shall be posted on the Department of Health's website and Board newsletter, and reported to the National Practitioner Data Bank and the Healthcare Integrity Protection Data bank.

Copies to:

Marc A. Brown, Esq.
LeClairRyan
2318 Mill Road, Suite 1100
Alexandria, Virginia, 22314

Pete Chattrabhuti, Esq.
Assistant Attorney General
Civil Enforcement Section
Public Interest Division
Office of the Attorney General
441 4th Street, N.W., Suite 630 South
Washington, DC 20001

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®

OFFICIAL USE

Certified Mail Fee
$

Extra Services & Fees (check box, add fee as appropriate)
- ☐ Return Receipt (hardcopy) $
- ☐ Return Receipt (electronic) $
- ☐ Certified Mail Restricted Delivery $
- ☐ Adult Signature Required $
- ☐ Adult Signature Restricted Delivery $

Postage

12/21/17
Postmark Here

7012 0660 0000 9797 1122

Marc A. Brown, Esq.
LeClairRyan
2318 Mill Road, Suite 1100
Alexandria, VA 22314

See Reverse for Instructions