BEFORE THE 
DENTAL BOARD OF CALIFORNIA 
DEPARTMENT OF CONSUMER AFFAIRS 
STATE OF CALIFORNIA

In the Matter of the Accusation Against: 

RALPH ANDREW LANDERMAN 
Dental License No. 19761 

Case No. DBC 2010-39 
OAH No. 2011010670 

Respondent.

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Dental Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on June 15, 2011

IT IS SO ORDERED May 16, 2011

John S. Bettinger, Board President 
Dental Board of California 
Department of Consumer Affairs
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Dental License No. 19761
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Respondent.

PROPOSED DECISION

Administrative Law Judge Nancy L. Rasmussen, State of California, Office of
Administrative Hearings, heard this matter on March 7, 8, 9 and 10, 2011, in Oakland,
California.

Deputy Attorney General Jonathan D. Cooper represented complainant Richard
DeCuir, Executive Officer, Dental Board of California, Department of Consumer Affairs.

John Fleer, Attorney at Law, represented respondent Ralph Andrew Landerman, who
was present.

The matter was submitted on March 10, 2011.

ISSUE

Is respondent’s ability to safely practice dentistry impaired due to a mental or
physical illness or disorder?

FACTUAL FINDINGS

1. On January 1, 1968, the Dental Board of California issued dental license no.
19761 to respondent Ralph Andrew Landerman. The current expiration date is April 30,
2012.

2. On April 21, 2008, at the age of 65, respondent suffered a left posterior
cerebral artery stroke which destroyed the entire visual cortex in the left occipital lobe of his
brain. It is believed that this stroke resulted from a blood clot caused by atrial fibrillation.
Respondent now takes Coumadin to prevent blood clots.
3. Respondent spent three days in the hospital after his stroke. The effects of the stroke which he experienced included a loss of peripheral vision on the right side, problems reading, and reduced energy and stamina. Respondent did not practice dentistry for at least three months, while he concentrated on his recovery. He received treatments from an acupuncturist and other health care practitioners. A month or two after his stroke respondent gave up his driver’s license after he realized how bad his “blind spot” was. (The first time he tried to drive his pickup he promptly drove off a dirt road on his property.)

4. In August or September 2008, respondent resumed practicing dentistry on a reduced schedule. Within a short time he was seeing patients three days a week for five to six hours a day. Respondent continued on this schedule until about January 2011, when he started working four days a week. Respondent does not have a “drill and fill” practice, although he does do composite fillings. He does crown and bridge work and lots of extractions, including complex impactions. Respondent’s practice is metal-free, and he does not perform root canal treatments. He has a loyal following of patients, many of whom travel a long distance to be treated by respondent.

5. According to respondent, not quite half his field of vision is gone, but he has learned to compensate by scanning with his eyes. He has used loupes (magnification devices attached to his glasses) for the last 20 years, and when he examines a tooth with his loupes he can see the whole tooth. Respondent asserts that he knows where his vision ends, and he has trained himself to consciously look at where a tool is in his hands. When viewing a radiograph, respondent scans the different parts to get a composite view of the radiograph. He denies having any problems viewing or interpreting radiographs.

Because of the area of his brain damaged by the stroke, respondent’s ability to read is severely impaired. He claims that with training his reading is improving and he can read a label on medication, for example. However, he relies on his dental assistant (Fahim Jooya, since June 2009) to read patient charts to him. Respondent can write his chart notes, and he claims he can read them but it is faster to have Jooya read them. When a new patient fills out a medical history form, Jooya reads it over to familiarize himself (Jooya) with it and then reviews the form with respondent, reading to him all the items marked “Yes.” If a patient brings in records from another doctor, Jooya reads to respondent the diagnostic reports and summaries and any other parts that Jooya thinks are important. Jooya assists respondent with every dental procedure. They go over a patient’s charts and x-rays together and decide if there are any special considerations regarding the anesthetic or tools to be used. Respondent tells Jooya what anesthetic he wants, and Jooya pulls the medication and sets it up on the tray. The anesthetic carpules are color-coded, and respondent relies on this to confirm that he is administering the correct medication.

Respondent denies having any problems with his short-term memory as long as he maintains his blood sugar level. If he misses a meal, he gets tired and his memory is not as sharp. Respondent structures his day around his meals to avoid this happening.
6. In June 2009, the Dental Board initiated an investigation of respondent after receiving a complaint from Ann Bogges, a dental assistant who had just left her employment with respondent. Bogges alleged that because of his impaired vision respondent often unknowingly cut into the cheek or tongue of a patient. She claimed that respondent had asked her to use a code word to alert him during treatments if he was cutting a patient’s cheek or tongue. Bogges also described two recent incidents that caused her concern. She said that on June 1, 2009, while performing an extraction, respondent tore gum tissue around the extraction site, causing severe bleeding. Bogges decided she could not continue to work for respondent after what happened with a patient on June 5, 2009. The patient had visible stitches in his mouth from surgery performed earlier that week, and respondent did not see or remember these stitches, according to Bogges. Then, when respondent extracted two teeth from the patient, gum tissue was torn and there was a lot of bleeding. Bogges said she became physically ill because of the amount of blood.

7. Respondent denies ever cutting a patient’s cheek or tongue accidentally, and denies asking Bogges to use a code word for anything. (Bogges did not testify at the hearing, so there is no non-hearsay evidence that this happened.) Respondent maintains that no patient has complained of injury and he has no reason to believe any of his patients are unhappy with their treatment. He points out that Bogges had a drug problem, for which he gave her five or six weeks off to attend a rehabilitation program, and after she left he discovered that she had obtained prescriptions for painkillers in respondent’s name without his knowledge.

Respondent explained the incident on June 5, 2009, and the patient, Jeff Haller, also testified about it. Haller was there that day to have two lower front teeth extracted. During the extraction of the first tooth, it became apparent that the two teeth were ankylosed together at the root and to the bony plate in front. (Because the two teeth were superimposed over each other, the ankylosis was not visible in the radiograph.) This ankylosis resulted in the bony plate breaking and coming out along with both teeth and some adhering tissue. This caused a lot of bleeding, and Bogges became upset and bolted from the room. Respondent compressed the area until she came back about 10 minutes later. After respondent cleaned the wound and contoured the bone with a bur, Bogges asked to leave again and was gone for at least another 10 minutes. Respondent had to wait for her return to do the suturing. Bogges arranged the sutures and assisted in the procedure. Respondent maintains that the Haller incident was not excessively bloody, and Bogges was upset because she did not understand what had happened. The circumstances of her departure from respondent’s employment are not clear. Respondent testified that he fired Bogges, after which she said: “You’re going to regret this; I’m going to make life difficult for you.” He later conceded that Bogges said she could not take it anymore and left. Bogges received unemployment insurance benefits (respondent’s attorney advised him not to contest her claim).

Haller faults Bogges for her unprofessional conduct and praises respondent for his skill, attention to detail, and empathy.
8. In August 2009, Dental Board investigator Kyle Clanton interviewed respondent and asked him to agree to a medical evaluation pursuant to Business and Professions Code section 820 (authorizing the board to order an evaluation if it appears that a licensee may be unable to safely practice due to mental or physical illness). Respondent said he needed to consult with his attorney; two weeks later, Clanton received a letter from respondent agreeing to a medical evaluation.

9. In October 2009, respondent was evaluated by functional neurologist Eric Hassid, M.D. On the recommendation of Dr. Hassid, respondent was referred to Glenn Hammel, Ph.D., for a neuropsychological assessment. Dr. Hassid had three assessment sessions with respondent, in February, March and April 2010, but because of scheduling problems, delays, and limitations on the length of time respondent was able to participate in a session, Dr. Hassid was unable to complete his assessment.

10. On October 11, 2010, the Dental Board issued an order pursuant to Business and Professions Code section 820 requiring respondent to submit to further examinations.

11. In November 2010, respondent was assessed by clinical neuropsychologist Alan E. Brooker, Ph.D. Dr. Brooker did not testify at the hearing, and his report is in evidence only as hearsay. On his recommendation, however, an evaluation by a neuro-opthalmologist was scheduled.

12. On or about January 19, 2011, respondent was evaluated by Jonathan C. Horton, M.D., Ph.D. Dr. Horton is a neuro-opthalmologist who has been on the faculty at UCSF Medical Center for 20 years. He is certified by the American Board of Ophthalmology, and he is a fellow of the North American Neuro-Ophthalmology Society. The primary focus of his research and career has been the visual cortex, and he is one of the foremost authorities on the anatomy and structure of the visual cortex. Dr. Horton has extensive experience with patients who have homonymous hemianopia ("hemianopia" means half-vision, and "homonymous" means it is identical in each eye).

Investigator Clanton had provided Dr. Horton with copies of his investigative report (detailing the complaint of Ann Bogges), Dr. Brooker's report and Dr. Hassid's report. Respondent brought with him the MRI images and a binder with additional records. Following the evaluation, Dr. Horton prepared a report which includes the following:

To test [respondent’s] memory, I told him 3 words, which I asked him to repeat out loud. I told him I would ask him the 3 words in a few minutes. When I quizzed him five minutes later on the identity of the three words, he could not recall any of them. I asked him to count backwards from 100 by serial 7’s. This task took him about 5 seconds per calculation, and he made two errors.
The visual acuity was 20/30 in the right eye and 20/40 in the left eye with his current spectacle correction.

Enclosed are copies of Humphrey 24-2 threshold tests. There is a homonymous scotoma [an area where vision is absent] in the right peripheral visual field. It is 15° from fixation. The scotoma is displaced from the vertical meridian because of frequent fixation errors. Dr. Landerman made frequent saccades [small involuntary eye movements] into the right hemifield because he was not able or willing to maintain fixation on the central target. This resulted in an unreliable map of his visual fields by the computerized, Humphrey perimeter, because it failed to reveal the full extent of his visual field loss.

I therefore performed Goldmann perimetry, a semi-manual form of visual field testing, which allows one to carefully monitor fixation and to disregard unwanted eye movements during visual field testing. Under these circumstances, Dr. Landerman was found to have a complete, macula-splitting right homonymous hemianopia. Copies of the Goldmann visual field tests are enclosed. By confrontation testing, I confirmed that Dr. Landerman has a complete right homonymous hemianopia. He could not detect my hand waving vigorously in his right hemifield of vision.

I next tested Dr. Landerman by asking him to read a sentence from Time Magazine written in bold, 30 point font. I chose a large font print so that his reduced near acuity would not limit his ability to read. Dr. Landerman was unable to read this sentence or comprehend it. He could identify individual letters but could not put them together to decipher individual words or to understand the concept conveyed by the sentence. I then dictated the sentence to Dr. Landerman. He was able to copy down the dictated sentence and explain its meaning to me.

I then put dilating drops in Dr. Landerman’s eyes. After dilation, I observed moderate nuclear sclerosis in both eyes. The optic disc, macula, and periphery were normal in each eye.

At this point, I finished my examination by performing a cycloplegic refraction in each eye. I could not improve the visual acuity to better than 20/30 in either eye.
**IMPRESSION:** Dr. Ralph Landerman is a 68-year-old dentist who suffered a major left occipital stroke in April 2008. The mechanism was presumably an embolus from his heart, which was in atrial fibrillation.

I personally reviewed an MRI of the brain performed on 19 Nov 2011 [sic]. It showed a massive left occipital lobe stroke, destroying all the brain tissue supplied by the left posterior cerebral artery. The normal brain tissue has been replaced by cerebrospinal fluid, leading to a condition called "encephalomalacia" in the left occipital lobe.

My neuro-opthalmological examination disclosed multiple deficits. I will summarize each deficit, and the impact of this deficit on Dr. Landerman’s ability to function as a dentist.

1) **Total, macula-splitting right homonymous hemianopia.** This deficit means that Dr. Landerman is completely blind in the right hemifield of vision in each eye. I am enclosing a brief chapter I wrote about Homonymous Hemianopia for a textbook “Curbside Consultation in Neuro-Opthalmology” 2009 to provide you with some background information about this condition. Unfortunately, Dr. Landerman’s right homonymous hemianopia is permanent and untreatable . . .

The homonymous hemianopia renders Dr. Landerman unfit to practice dentistry. Even if he had no other deficits, this lesion by itself would be sufficient to make it impossible for him to examine patients and to perform dental procedures safely. The reason is that when Dr. Landerman looks at a visual target to perform a procedure, the right half of the visual scene is missing. In other words, the visual world seen by each eye is split in two, with Dr. Landerman suffering from complete blindness in the right half. To make matters worse, he is not fully awake [sic] of this deficit. To examine a patient’s teeth, or to perform a dental procedure skillfully, one must be able to appreciate the entire visual scene. If the dentist is blind to half the scene, he is likely to fail to observe significant findings or lesions. In attempting to perform a procedure, the dentist will be disoriented visuospatially, and unable to properly use visual input to guide delicate hand and finger movements. It is not possible for a dentist to perform dental examinations reliably or skillfully if his visual function is impaired by complete homonymous hemianopia.
2) **Alexia without agraphia.** This condition means that Dr. Landerman is unable to read or comprehend printed or handwritten text. Although he is a well-educated man, the stroke he suffered has rendered him functionally illiterate. His alexia (inability to read) is an unusual condition, and is a reflection of the severity of his 2008 stroke. The damage to the left side of his brain extended from the occipital lobe far anteriorly, all the way to the brainstem. It has damaged a vital fiber bundle, called the splenium of the corpus callosum. The function of this structure is to transfer visual information from one occipital lobe to the other. The interruption of the corpus callosum by his cortical stroke means that he cannot transfer visual information from his intact right occipital lobe to his speech centers, which are located in his left temporal lobe. His left occipital lobe has been destroyed. Because he has no cortical mechanism to transfer visual information from his remaining right occipital lobe to his left temporal lobe, he cannot comprehend written language. However, Dr. Landerman can understand and write down verbal information, because it enters through his auditory cortex, which remains undamaged on the left side of his brain.

Cortical alexia explains why Dr. Landerman relies upon assistants to read written text to him. He cannot read anything—even his own handwriting. Although he can write, the inability to read what he has written makes it difficult for him to keep adequate and coherent clinical notes on patients in his practice.

3) **Cognitive Impairment.** I performed only limited neuropsychiatric testing in my office today. However, it was apparent that Dr. Landerman has some impairment of short-term memory and his ability to perform simple calculations. In this context, it is significant that the left-side stroke he suffered destroyed not only the occipital lobe, but also the left hippocampus. The hippocampus is a vital structure for short-term memory function. Loss of one hippocampus can impair memory function.

4) **Cataracts.** Dr. Landerman has moderate cataracts in both eyes, reducing his visual acuity to a level of 20/30 in each eye. I recommend cataract surgery to restore his visual acuity to 20/20, which is a normal level of visual acuity. However, restoration of normal visual acuity would not make him fit to practice dentistry, because it would not correct his right homonymous hemianopia or his alexia.
I have been engaged in research on the human visual system at UCSF for 20 years. During this time, I have also been involved heavily in the care of patients with brain lesions which affect visual function. I have personally cared for hundreds of patients like Dr. Landerman with occipital lobe stroke.

13. Respondent claims he was not at his best during Dr. Horton's evaluation and this affected his performance. He and his wife were late because of a car problem, they had to wait in Dr. Horton's office for an extended period of time, and he got hungry and had to get something to eat. Respondent has chemical sensitivities, and he thinks he had an allergic reaction to substances in Dr. Horton's office. He also found Dr. Horton to be arrogant and felt threatened by him throughout the evaluation. The following day, respondent wrote a letter to Dr. Horton raising the issues he felt had negatively affected his performance. Respondent surmised that he had not "passed" Dr. Horton's tests, but he denies that this was why he wrote the letter.

14. Based upon Dr. Horton's report, complainant filed a petition for interim order of suspension of license pursuant to Business and Professions Code section 494. Following a hearing on February 14, 2011, an interim order was issued on February 15, 2011, restricting respondent to performing examinations and consultations only, and prohibiting him from performing any dental procedures.

15. Respondent arranged to be evaluated by another neuro-opthalmologist, August L. Reader III, M.D. Dr. Reader has a private practice with Pacific Eye Associates in San Francisco, and he is a clinical professor of medicine (the highest volunteer teaching position) at California Pacific Medical Center. He is certified by the American Board of Ophthalmology, and he is a fellow of the North American Neuro-Ophthalmology Society.

Dr. Reader was provided with Dr. Horton's report, Dr. Brooker's report and various other documents. He conducted his evaluation of respondent on March 2, 2011, and prepared a report which includes the following:

Dr. Landerman's neuro-opthalmic examination on March 2, 2011 revealed visual acuity of 20/50+2 in the right eye and 20/25+1 in the left eye with his present glasses. Pinhole correction of his visual acuity to 20/25+2 in the right and 20/25+2 in the left was obtained. . . . Confrontation visual fields revealed a right visual field defect in his right eye including both the inferior and superior quadrants with the field defect in the left eye being present in the superior quadrant only. Testing with a 30-2 threshold protocol reveals a right homonymous scotoma in each eye with the scotoma beginning approximately 5 to 7 degrees to the right of fixation. There was excellent fixation with each eye on these tests. Anterior segment
examination was within normal limits with thinning of the
irides, worse on the right than the left. There was trace nuclear
sclerotic cataract change in the lenses of each eye. . . .

I performed the same “mini neurological tests” that Dr. Horton
performed. I asked Dr. Landerman to remember three objects,
which were “apple, bus, and skyscraper,” which he repeated for
me. . . .

I performed a cycloplegic refraction and with a refractive error
of +0.75+0.50×145 in the right eye, I was able to obtain a vision
of 20/20. In the left eye, with a refractive error of
+0.50+0.50×165 degrees, I also obtained a vision of 20/20 in the
left eye. With this correction and both eyes open, Dr.
Landerman was able to see 20/15-1.

Optical coherence tomography of the optic nerves was
performed and confirmed loss of maculopapular bundle in the
right eye and the superior and inferior arcuates of the left eye. I
reviewed the MRI images of Dr. Landerman’s brain that were
performed in November 2010 and find that he has had an
infarction of the left occipital region extending anteriorly to the
level of the lateral geniculate body. There is also involvement
of the splenium of the corpus callosum. However, I did not see
any extension into the left hippocampus as discussed by Dr.
Horton.

In evaluating the visual fields performed by Dr. Valerie Garden
on February 24, 2011 and the visual fields performed in my
office on the day of my evaluation, there were no fixation losses
in Dr. Landerman’s right eye and only one fixation loss in his
left eye on the day of my examination. There were no fixation
losses in the left eye and one fixation loss in the right eye on the
examination of Dr. Garden. In both of these visual fields, there
is a clear extension of normal vision at least five degrees to the
right of fixation in both eyes, thus being very consistent that Dr.
Landerman does not have a macular splitting homonymous
hemianopia.

Dr. Landerman’s cerebrovascular accident has caused a right
homonymous scotoma in his visual fields with probable
extension into the lateral geniculate body with antegrade
atrophy of the optic nerves as evidenced on optic nerve
examination and optical coherence tomography. I do not feel
that the homonymous hemianopia is splitting his fixation since I
was able to correct his vision to 20/20 in each eye and he had 20/15 vision with both eyes and corrected vision.

On memory testing, he was able to correctly remember three objects after five minutes and perform serial seven subtractions from 100 without any mistakes in less than 45 seconds. Hence I do not feel that Dr. Landerman has any short-term memory loss or difficulties with calculations. He admits to having difficulty reading and this is consistent with the type of cerebrovascular accident he sustained in April 2008. I disagree with Dr. Horton that he has significant cataract change that decreases his vision since I was able to correct his vision to 20/20 in each eye.

I also examined the loupes that Dr. Landerman uses for his dental work. The loops [sic] are 3.8 magnification and the field of view is less than 15 degrees. Hence, with his visual field of 5-7 degrees to the right of fixation and a full field to the left, he has a full field view through the loupes except for possible 2-3 degrees to the right hand side. This should not hamper him in any way from performing accurate dental work.

On the points that were given by Dr. Horton in his declaration, I respond to the following:

1. Dr. Landerman does suffer from a right homonymous visual field defect, but does not have a macula splitting field and has sufficient partial peripheral vision to the right that allows him to see completely through his optical loupes used for dental work.

2. I do agree with Dr. Horton that he suffers from alexia without agraphia, but do not feel that this limits his ability to perform dentistry just because he is unable to read or comprehend text. Those abilities are not necessary to perform appropriate dental procedures.

3. I disagree with Dr. Horton that Dr. Landerman suffers from short-term memory loss and inability to perform simple calculations. Hence, I do not feel those are hindrances to his practicing dentistry.

4. Dr. Landerman does have trace nuclear sclerotic cataract changes in both eyes, but his vision can be improved with glasses to 20/20 in each eye and he obtains vision of 20/15 with both eyes open and with the proper correction.
I do not feel that the visual-spatial problems of Dr. Landerman are the hindrance to his practice of dentistry. I do not feel that he has any short-term memory loss nor does he have any difficulty with calculations.

I have been practicing neuro-opthalmology for over 30 years and have seen 100's of patients with cerebrovascular accidents, most of which have had lesions that affected the visual system.

16. Dr. Horton had reviewed Dr. Reader's report before testifying at the hearing. He asserted that if Dr. Reader had performed the Goldmann perimeter test, rather than just the Humphrey test ("30-2 threshold protocol") and confrontation testing, it would have led him to believe that the apparent sparing of vision of five to seven degrees on the right side of respondent's visual field was spurious. It is very difficult for patients with homonymous hemianopia to maintain fixation on the central target. On Dr. Reader's Humphrey test, respondent had only one fixation loss measured by blind spot checking, but the jagged line along the bottom of each test printout shows innumerable eye movements away from the target. And the Humphrey machine cannot tell where the eye is focused for each particular flash of light in the test. In the Goldmann test, an operator sits behind a telescope and checks the focus of the patient's eye while lights move in from the periphery and the patient clicks the button. The only points accepted are those harvested when the eye is fixated in the center. "Bogus" points, when the eye is wandering or making stray movements, are discarded. This corrects for the problems with the Humphrey test. Another reason Dr. Horton believes Dr. Reader's Humphrey test results for respondent are inaccurate is that a sparing of vision of five to seven degrees is not possible with the complete destruction of the visual cortex.

Dr. Horton believes Dr. Reader made a mistake when he reported: "Confrontation visual fields revealed a right visual field defect in his right eye including both the inferior and superior quadrants with the field defect in the left eye being present in the superior quadrant only." When the problem is cortical, the visual field defects are the same in both eyes. Dr. Horton believes the following statement by Dr. Reader is in error: "I do not feel that the homonymous hemianopia is splitting his fixation since I was able to correct his vision to 20/20 in each eye and he had 20/15 vision with both eyes and corrected vision." Aside from the fact that Dr. Horton does not think respondent's corrected visual acuity is better than 20/30, having 20/20 vision does not rule out complete homonymous hemianopia. (Given enough time, a patient with complete homonymous hemianopia will pick their way across the eye chart.)

Elaborating on the problems created by respondent's homonymous hemianopia, Dr. Horton testified that relying on random saccades to the right side to pull together a full picture of the mouth presents a risk of mishaps during surgical procedures. During dental surgery there is a need to fixate on a small surgical field, and looking involuntarily off to one side interferes with the ability to focus on the task at hand. Even when using loupes, peripheral vision is necessary to safely maneuver tools in and out of the surgical field. Dr.
Horton is skeptical that respondent could have functioned as a dentist since his stroke without mishaps, but assuming that to be true he would not change his opinion that respondent's complete homonymous hemianopia precludes him from safely practicing dentistry.

Dr. Horton acknowledged that his testing of respondent's cognitive functioning was very limited, and he deferred to Dr. Brooker on memory testing. As part of his neuropsychological evaluation Dr. Brooker administered the Wechsler Memory Scale-III. In discussing the results of his evaluation Dr. Brooker wrote that:

... the memory testing results revealed superior range immediate and delayed auditory memory function, as well as high average range memory for faces. However, on a task requiring memory of complex drawings of social situations, Dr. Landerman performed within the borderline range on, both, the immediate and delayed trials. This is far below expectancy given his demonstrated educational history, work history and innate intellectual capabilities. On the other hand, again, this was not unexpected given Dr. Landerman's significant visual field deficits.

[1] ... [4]

In conclusion, I have no reservations regarding Mr. Landerman's ability to perform the cognitive tasks required in his profession. However, his visual perceptual deficits raise obvious concern and should be addressed in a neuro-opthalmological evaluation.

Dr. Horton pointed out parts of Dr. Brooker's report which were consistent with his findings. Dr. Brooker reported that "on executive function tasks that required swift and accurate visual perception, he performed poorly." Dr. Brooker also reported:

Hence, overall, one could conclude that he is well-adjusted. This theory would tend to be supported by his apparent attempt to accommodate for his visual field deficits by spending an extraordinary amount of time to scan visual stimuli. However, after being advised of his visual-dependent mistakes on relatively easy tasks, he tends to downplay the significance, exhibiting a well-developed denial.

17. In his testimony Dr. Reader explained that the Goldmann perimeter test used to be "the gold standard," but it is more subjective than the Humphrey test because of the involvement of a human examiner. Now most neuro-opthalmologists use the Humphrey
30-2 as their visual field test of choice. Dr. Reader asserted that the jagged line along the bottom of each Humphrey test printout reflects only very slight eye movements away from the target, probably less than one-half degree in either direction. These eye movements are within normal limits and do not necessarily invalidate the test results.

Dr. Reader acknowledged that destruction of the entire left visual cortex should result in complete right homonymous hemianopia, but asserted that there may be other pathways in the brain that account for a sparing of some of the visual field. Although Dr. Reader believes respondent’s right homonymous hemianopia is not complete, he does not think complete right homonymous hemianopia would preclude respondent from practicing dentistry. He believes the brain’s normal adaptive mechanism of small saccades to the side where vision is impaired would enable respondent to adequately compensate for his visual field deficit.

18. Ronni Brown, D.D.S., M.P.H., is a general dentist who testified as an expert witness for complainant. Based upon the information in Dr. Horton’s report, Dr. Brown believes respondent is unable to safely practice dentistry. Assuming respondent has not injured any patients since his stroke, her opinion is unchanged because of the significant risk and potential for injury. (Dr. Brown pointed out that patients might not know if they were accidentally injured during a dental procedure; patients are fairly unaware of what is involved in a dental procedure and they are often numb during procedures.) Dr. Brown testified that during a dental procedure a dentist must be able to focus on a tooth, but also be aware of where his hands and tools are, be aware of the periphery of the tooth as well as the gum, cheek and tongue, and be aware of where the dental assistant’s hands and tools are positioned. This requires peripheral vision, which respondent does not have on the right side. Regarding respondent’s alexia, Dr. Brown testified that a dentist must be able to read patient medical histories, patient charts and labels on medication. It is not acceptable to rely on a dental assistant for these tasks. Even assuming respondent’s vision problems are not as serious as reported by Dr. Horton, and assuming he does not have short-term memory deficits and he can read a medication label, Dr. Brown still believes respondent cannot safely practice dentistry.

19. Samuel Eccles, D.D.S., is a general dentist who has referred patients to respondent and who has been a patient of respondent’s. In his testimony Dr. Eccles expressed agreement with the view of two other dentists who wrote letters on respondent’s behalf stating that a dentist does not need to have peripheral vision. Using loupes diminishes the dentist’s field of vision, and Dr. Eccles does not think a dentist needs to see the rest of the patient’s mouth when he is working on one tooth.

On March 6, 2011, Dr. Eccles observed respondent perform two dental procedures on a typodont dental model. This took place in Dr. Eccles’s dental operatory, and he picked the procedures for respondent to perform. In Dr. Eccles’s opinion, respondent performed the procedures competently.

20. Monica Pozzi is a registered dental assistant who worked for respondent for about five weeks in March or April 2008, before his stroke. She met Ann Bogges then
because they both worked for respondent. After respondent returned to work following his stroke, Pozzi filled in for Bogges a few times before taking her place during the five weeks Bogges was on leave during the spring of 2009. Pozzi recalls that on the first morning of Bogges’s leave respondent told her he had lost his peripheral vision and asked her to be his second pair of eyes in case he veered off from his procedure. Pozzi noticed a difference between respondent’s performance before his stroke and after. After the stroke, respondent’s procedures took longer and in some preparations there seemed to be more bleeding (from respondent hitting the sulcus rather than the tooth). Pozzi also noticed that after respondent’s stroke some crowns he fitted did not fit as accurately as they had before. However, the only time Pozzi observed respondent accidentally cut a patient’s tongue was before his stroke.

21. Registered dental assistant Fahim Jooya has worked for respondent since June 2009, and he testified at the hearing. Jooya has never seen respondent unintentionally cut a patient’s cheek or tongue or otherwise injure a patient, nor has he seen anything he would identify as a mistake in a dental procedure. Jooya heard something about respondent having had a stroke, but he is unaware of him having any problems with his peripheral vision.

22. The Dental Board has incurred the following costs in the investigation and prosecution of this case:

**Investigative Services**
14 hours @ $88.80/hour  $1,243.20  

**Consultant Services**  
$9,807.25  

**Attorney General Services**  
32.25 hours @ $170/hour  
$5,752.95  

**TOTAL COSTS:**  
$16,802.95  

**DISCUSSION**

The accusation alleges that respondent is unable to safely practice dentistry and cites the findings made by Dr. Horton regarding total macula-splitting right homonymous hemianopia, alexia without agraphia, impairment of short-term memory and inability to perform simple calculations, and cataracts.

The evidence does not establish that respondent has short-term memory problems or an inability to perform simple calculations, and his cataracts would not preclude him from safely practicing dentistry. The real issues in this case are the extent and impact of respondent’s right visual field deficit and the impact of his alexia.

Dr. Horton and Dr. Reader are both eminent neuro-ophthalmologists, but Dr. Horton was persuasive in his opinion that respondent has complete (macula-splitting) right homonymous hemianopia, i.e., respondent cannot see anything on the right side of the visual
field. This was what the Goldmann perimeter test showed, and it is consistent with the undisputed total destruction of respondent's left visual cortex. Dr. Reader did not perform the Goldmann test, and there are some questions about the reliability of his Humphrey test results. The suggestion that Dr. Horton somehow skewed the results of the Goldmann test to conform to his expectations is rejected as implausible and unsupported by the evidence.

Respondent appears to have compensated for his right homonymous hemianopia to a large degree by involuntary saccades and deliberate scanning of the right visual field, and the evidence does not support a finding that any patient has been injured because of respondent's loss of vision. Nonetheless, the evidence from Dr. Horton and Dr. Brown establishes that respondent's visual field deficit presents a significant risk and potential for injury to patients. Dr. Reader was not persuasive in his opinion that respondent has adequately compensated for his visual deficit (even assuming he has complete right homonymous hemianopia) such that he can safely practice dentistry. The opinion that peripheral vision is not necessary for the safe practice of dentistry was not persuasive.

Even if respondent can read a medication label, his inability to read patient charts, medical histories and records from other doctors presents serious cause for concern. Dr. Brown testified that it is not acceptable for a dentist to rely on a dental assistant for these important tasks. The fact that respondent's assistant uses his own judgment in deciding what parts of voluminous records to read to respondent illustrates the soundness of Dr. Brown's opinion.

Complainant has established that respondent is unable to safely practice dentistry by reason of his complete right homonymous hemianopia and his alexia.

LEGAL CONCLUSIONS

1. Business and Professions Code section 822 provides:

   If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:
   (a) Revoking the licentiate's certificate or license.
   (b) Suspending the licentiate's right to practice.
   (c) Placing the licentiate on probation.
   (d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

2. Respondent is subject to action under Business and Professions Code section 822 because his ability to safely practice dentistry is impaired by his complete right homonymous hemianopia and his alexia. These conditions constitute physical illnesses affecting competency within the meaning of this section.
3. Because of the potential risk to patients, it would be contrary to the public interest to allow respondent to keep his dental license.

4. Complainant has requested that respondent be ordered to pay the board the costs of investigation and enforcement of the case. Business and Professions Code section 125.3 provides that “a licentiate found to have committed a violation or violations of the licensing act” may be ordered to pay the board “a sum not to exceed the reasonable costs of the investigation and enforcement of the case.”

   Respondent is not subject to cost recovery under this section because he has not committed any violation of the Dental Practice Act (Bus. & Prof. Code, div. 2, ch. 4, § 1600 et seq.).

ORDER

   Dental license no. 19761 issued to respondent Ralph Andrew Landerman is revoked.

DATED: April 12, 2011

NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings