OREGON BOARD of DENTISTRY
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PRESIDENT'S MESSAGE

by Norman D. Magnuson, D.D.S., President 2010-2011

Right now I'm sitting in a CE course where an argument has developed. This is a difficult topic to understand and it is assumed the instructor knows more than the students. The instructor is trying to clarify information and some of us are having a difficult time accepting the meaning of the topic. Even though it is difficult, we are communicating and working together in our ideas and thoughts. Hopefully at the end of the day we understand each other better and still get along.

This same concept occurs at the Board level. There are times when Board members discuss difficult situations with differing opinions. We listen to each other's viewpoint and work together to come to a conclusion. We don't always agree and we don't always vote the same. At the end of the day we understand each other better and we still get along.

The Board interacts with people and organizations. Most of these we represent in one way or another, whether it's dentists, hygienists, assistants, the public or organizations. If I have learned one thing throughout the years of service, there are three areas that need to be met if we are going to work together. There has to be communication, collaboration and cooperation if we are to move forward.

The Board tries to be open in its communication. One way we do this is to have the Executive Director and the Dental Director speak at various dental meetings. We have open sessions at Board meetings so the public can listen or have input into the discussion at hand. A call to the Board Office can answer many questions. We also work together with many associations, institutions and organizations. The success in these areas definitely depends on each other's cooperation. Honest and upfront communication on all of our behalves will allow us to understand each better and still get along at the end of the day.

The Mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care. This task is not always straight forward or easy, but I am sure with good communication, collaboration and cooperation it can be done. ■

WHAT'S INSIDE

Executive Director 2
Our Obligation to Report 3-4
Disciplinary Actions 5-13
New Board Members 14
Farewell to Board Member 14
OBD Rule Changes 15
2011 Legislative Session 15
License Renewal Notification 16

PRACTICING WITHOUT AN ACTIVE LICENSE

The Oregon Board of Dentistry has recently developed a protocol that if a licensee fails to renew their license and continues to practice, they will be subject to disciplinary action by the Board. The Board feels that this is a very serious matter as all licensees are aware of the date that their license expires. Dental Licenses expire March 31 and Dental Hygiene Licenses expire September 30 of the respective years.

Dentists Notices of Proposed Disciplinary Action will be issued and Consent Orders offering a Reprimand and $5,000 Civil Penalty.

Dental Hygienists Notices of Proposed Disciplinary Action will be issued and Consent Orders offering a Reprimand and $2,500 Civil Penalty. ■

50 Years

by Patrick D. Braatz, Executive Director

I was born in 1961, so 2011 meant that I reached that big milestone of 50 years; it came and passed without too much trepidation.

Recently while waiting in the library of the Oregon Medical Board office for a meeting of other Health Board executive directors, I noticed that they had a collection of Oregon Laws dating back to almost the beginning of Oregon statehood. I happened to grab the 1961 book and looked to see if there was any legislation passed regarding the Oregon Board of Dentistry (OBD) during the 1961 session of the Oregon Legislature. Sure enough, there was the OBD budget bill. The biennial budget for the OBD in 1961 was a little over $50,000 and they actually had in legislation that the licensure fee was $50.

As they say, things do change over time. The 2011-2013 OBD budget is just under $2,500,000 and the dental license application fee is $345 and the dental licensure fee is $315. However, $55 of that fee is collected by the OBD but is directly transferred to other state agencies, with another $85 that the OBD pays to other state agencies for services that it provides to the OBD. This is a growing trend that is happening in many states as a way to fund other parts of state government.

I am not sure how many licensees were regulated by the OBD in 1961, but today we have approximately 7,200 licensees which include dentists and dental hygienists. While we do not directly regulate dental assistants, we regulate how dentists and dental hygienists can use dental assistants in their practice by issuing over five different dental assistant certificates.

For dental hygienists, we issue four different endorsements and permits and we also issue five different levels of anesthesia permits to licensees.

I am also not sure how many complaints the OBD investigated in 1961, but during the 2009-2011 Biennium we opened 500 complaints and completed 433 investigations.

Because of the recent economic downturn, the OBD is investigating more complex complaints from consumers who have not been seen by just one dentist, but sometimes as many as six different dentists. The OBD is also seeing more malpractice claims that must be investigated by the OBD.

Senior OBD employees who are eligible for significant time off, along with state government treating Other Funds agencies like the OBD as they do General Funds agencies by requiring furlough days from OBD staff, have **decreased** the time available to investigate these complaints. At the same time, the number and complexity of the complaints are on the rise. The bottom line is that we are not processing the complaints as fast as we once did and no one is happy about that.

Ever since I came to the OBD almost nine years ago, I have worked with the Board and staff to look at ways that we could become more effective, efficient and cost conscious and we have done much.

Converting the Board agenda from a 1,000-page book for 18 people to an electronic version has saved staff time, paper, printing and postage costs.

Placing all applications on line for applicants to access through our Web site has saved staff time, paper, printing and postage costs, as well as not wasting applications when changes are made.

Creating an on-line renewal process has saved staff time, printing, paper and lots of postage costs and has allowed us to mail reminder postcards at least twice during the renewal cycle, something we weren't able to do with the paper renewals. The next step will be an electronic form of notification for the on-line renewal process, as well as the follow-up notices, which could save us even more.

The 2013 – 2015 Biennial Budget process, as well as the 2013 Legislative Session, will bring new challenges and require the OBD to look for more efficiency and cost savings.

So stick around, although I am not sure we will all be here in 50 years to look back at the next 50 years!!!!! ■

Radiographs

The Standard of Care in Oregon requires that current radiographs are available prior to providing treatment to a patient. If a patient without a medical justification refuses to allow radiographs to be taken, even with the offer to sign a waiver, then providing treatment to that patient would violate the Standard of Care in Oregon.

Our Obligation as Healthcare Workers to Report Domestic Violence

By Patricia A. Parker, D.M.D.

Research indicates that most physical injuries resulting from family violence are found on the head and neck, areas that are clearly visible to the dental team during examinations. This gives us a unique opportunity to recognize signs of family violence in our patients and places a vital responsibility upon each of us as well.

Domestic Violence is the leading cause of traumatic injury to women in the U.S. It requires the use of precious resources such as social services, law enforcement, health care and the legal system. The cost of domestic violence may be as high as $5 - $10 billion annually for medical expenses, police and court costs, shelters and foster care, sick leave, absenteeism, and non-productivity.

Domestic violence includes physical abuse, sexual abuse, psychological abuse, exploitation and neglect. Domestic violence is pervasive in our society, crossing all lines of race, culture, economics, religion, and age. It affects people from all walks of life.

The long lasting effects of domestic violence are devastating. A person can suffer adverse

consequences for life. Abusive behavior is often passed on to future generations when it is not extinguished. Two thirds of violent offenders of all crimes were physically abused as children.

Since we, as dental professionals, routinely assess the head, face and neck of patients, we have a unique opportunity to identify the signs of family violence. Often victims of domestic violence will seek treatment for dental injuries even when they are reluctant to see a physician for other injuries. Dental professionals may observe physical injuries such as chipped or cracked teeth, poor dental hygiene, a broken jaw, a black eye, a broken nose, upper arms, or wrists.

In addition to child abuse, neglect and partner abuse, domestic violence also includes the abuse and neglect of the elderly and people with disabilities. It is estimated that between 1 and 2 million Americans age 65 or older have been injured,

(continued on page 4)

OUR OBLIGATIONS

(Continued from page 3)

exploited, or otherwise mistreated by someone on whom they depended for care or protection. More than 20,000 complaints of elder abuse or neglect were received and more than 12,000 complaints were investigated by the Oregon Department of Human Services.

Even though every state requires dentists to report when they suspect child abuse or neglect, less than 1% of all child abuse reports nationwide are made by dental professionals.

What is our obligation in reporting suspected domestic violence or abuse of the elderly and disabled?

Oregon law[1] mandates that workers in certain professions must make reports if they have reasonable cause to suspect abuse or neglect. These people are called mandatory reporters and they are a crucial link in the system to protect Oregon's most vulnerable citizens. Mandatory reporters include physicians (including interns or residents), psychologists, dentists, and others that are involved in the examination, care or treatment of patients. Suspected child abuse is reported to your local Child Welfare office of the Department of Human Services. For information on your local contact go to: http://www.oregon.gov/DHS/children/abuse/cps/cw_branches.shtml.

Although dentists are not considered mandatory reporters of elder abuse and abuse of the disabled, we have a responsibility as citizens and an ethical obligation as dental professionals[2] to protect those who cannot protect themselves. To report abuse of seniors or those with disabilities, call the Oregon Elder Abuse Hotline at 1-800-232-3020 or get more information at www.oregon.gov/DHS/spwpd/abuse/index.shtml.

There is much debate regarding what role clinicians play in screening for intimate partner violence (IPV). There are resources available to help practitioners with recognizing and acting on suspected IPV. You probably have patients in your practice that are experiencing IPV or experienced it in the past. These patients may be suffering long term consequences of their abuse and knowing that can help you in formulating a treatment plan. You may also be able to refer victims to services and provide information about domestic violence. The Family Violence Prevention Fund provides educational materials, screening protocols, and technical assistance on IPV for health professionals. http://endabuse.org/section/programs/health_care.

Please take the time to become familiar with domestic violence. Learn how you can help and who to contact should you need to report child abuse, elder abuse or abuse of the disabled. ■

1 ORS 419B.010 requires any public or private official having reasonable cause to believe that any child (unmarried and under 18 years of age) with whom the official comes in contact has suffered abuse or that any person with whom the official comes in contact has abused a child shall immediately report or cause a report to be made in the manner required in ORS 419B.015.

2 ADA Principles of Ethics and Code of Professional Conduct 3.E.1. states: Dentists are obligated to keep current their knowledge of both identifying abuse and neglect and reporting it in the jurisdiction(s) where they practice.

RESOURCES

- Child Abuse Hotline (24-hour) 800- 4-ACHILD
- Center for the Prevention of Domestic Violence: www.corasupport.org
- National Center on Elder Abuse (NCEA): www.ncea.aoa.gov
- National Coalition Against Domestic Violence: www.ncadv.org
- National Health Resource Center on Domestic Violence: 888-Rx-ABUSE (888-792-2873); www.endabuse.org
- P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) Program designed to train dental professionals and other healthcare providers to recognize and respond to signs of abuse and neglect in their patients. www.dccontract.com/midatlanticpanda/html/about.html. ■

FAILING TO RELEASE PATIENT RECORDS

818-012-0030 Unprofessional Conduct The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:

(9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:

(A) Legible copies of records; and

(B) Duplicates of study models and radiographs, photographs or legible copies thereof if the radiographs, photographs or study models have been paid for.

Disciplinary Actions Taken Between August 1, 2009 and September 30, 2011

Unacceptable Patient Care ORS 679.140(1)(e)

Case #2009-0142 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to diagnose and document an open crown margin and incomplete endodontic fills, and failed to document informed consent and a dental justification for providing treatment. In a Consent Order, the Licensee agreed to be reprimanded, to complete three hours of continuing education hours in record keeping, and to not perform endodontic therapy on molar teeth until completing 30 hours of Board approved hands-on continuing education in endodontic therapy.

Case #2009-0041, 2009-0061, 2009-0072, 2009-0080, and 2009-0089 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, on numerous occasions, failed to document in the patient records obtaining informed consent prior to providing treatment; provided treatment without a dental justification; and failed to document the results of examinations and diagnoses, failed to document the taking of radiographs. In a Consent Order, the Licensee agreed to be reprimanded, to complete a three hour course in record keeping and an eight hour course in treatment planning, and if the Licensee's dental license is reactivated, the Licensee will provide 40 hours of pro bono dental care.

Case #2009-0252 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist made misleading statements when the Licensee attempted to lead the patient into having surgical laser therapy to treat a periodontal disease process that the patient did not have. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $1,000.00 civil penalty.

Case #2008-0286 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the four hours of continuing education required for nitrous oxide permit renewal for the 2005-2007 license renewal period, on January 30, 2007 made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dentistry in Oregon when the Licensee declared and signed the application certifying that the Licensee had completed the required continuing education hours, did not identify the Licensee as a General Dentist in an advertisement, and administered Restylane filler on a number of patients without the appropriate training. In a Consent Order, the Licensee agreed to be reprimanded and pay a $1,000.00 civil penalty.

Case #2008-0248 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment and failed to deliver and seat a permanent crown. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2008-0151 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist overfilled root canals, seated crowns with open margins, placed restorations with open contacts and overhanging margins, perforated a tooth while placing a pin, and provided nitrous oxide sedation without first obtaining a nitrous oxide permit. In a Consent Order, the Licensee agreed to complete the five day R.V. Tucker Cast Gold Restoration Course, to have the Licensee's employer review the Licensee's dental records, and to complete a three hour course in record keeping.

Case #2009-0202 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to maintain patient records and radiographs for at least seven years from the date of the last entry. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $2,000.00 civil penalty.

(continued on page 6)

DISCIPLINARY ACTIONS (Continued from page 5)

Case #2008-0045 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to test heat sterilizing devices and allowed uncertified dental assistants to expose dental radiographs, seat temporary crowns, place soft denture relines, and place pit and fissure sealants. In a Consent Order, the Licensee agreed to be reprimanded, pay a $2500.00 civil penalty, and provide the Board with the results of spore testing.

Case #2009-0232 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, on numerous occasions, failed to document in the patient records obtaining informed consent prior to providing treatment; provided treatment without a dental justification; prescribed medication without a dental justification; failed to document treatment that was provided, failed to document treatment complications; failed to document the administration of local anesthetic, and seated a crown with an open margin. In a Consent Order, the Licensee agreed to be reprimanded, to complete a three hour course in record keeping and at least 20 hours of Board approved hands-on continuing education in endodontics.

Case #2010-0232 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to obtain informed consent from a patient's guardian prior to extracting two teeth. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0104 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, on numerous occasions, failed to document in the patient records obtaining informed consent prior to providing treatment; failed to document treatment that was provided and failed to treat or protect an exposed retained tooth root before seating a bridge over the exposed root. In a Consent Order, the Licensee agreed to be reprimanded, to complete a three hour course in record keeping, and to pay a $2,000.00 civil penalty.

Case #2010-0053 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, on numerous occasions, failed to document in the patient records obtaining informed consent prior to providing treatment; provided treatment without a dental justification; failed to document treatment that was provided; and administered nitrous oxide without taking vital signs and fully documenting the administration and the patient's condition. In a Consent Order, the Licensee agreed to be reprimanded and to complete a three hour course in record keeping.

Case #2010-0017 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment; provided treatment without a dental justification; prescribed medication without a dental justification; failed to document treatment that was provided; failed to complete endodontic therapy in a tooth; and failed to document the administration of local anesthetic. The Licensee failed to request a hearing in the matter so the Board issued a Default Order in which the Licensee was reprimanded and ordered not to apply for reinstatement of the Licensee's dental license.

Case #2009-0279 The Board issued Notices of Proposed Disciplinary Action to two dentists, alleging that the Licensees, for multiple patients, administered conscious sedation without first obtaining a conscious sedation permit; failed to document the patients' vital signs and condition upon discharge; and failed to accurately document medication that was prescribed. The Licensees each entered into a Consent Order with the Board in which each Licensee agreed to be reprimanded.

Case #2010-0117 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist prescribed controlled substances outside the scope of dentistry for a patient and then failed to document the prescriptions in the patient's record. In a Consent Order, the Licensee agreed to be reprimanded.

(continued on page 7)

DISCIPLINARY ACTIONS (Continued from page 6)

Case #2010-0230 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist's advertisement did not describe the Licensee as a general dentist or as practicing general dentistry. In a Consent Order, the Licensee agreed to pay a $500.00 civil penalty.

Case #2010-0231 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist's advertisement did not describe the Licensee as a general dentist or as practicing general dentistry. In a Consent Order, the Licensee agreed to pay a $500.00 civil penalty.

Case #2010-0227 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist's advertisement did not describe the Licensee as a general dentist or as practicing general dentistry. In a Consent Order, the Licensee agreed to pay a $500.00 civil penalty.

Case #2010-0228 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist's advertisement did not describe the Licensee as a general dentist or as practicing general dentistry. In a Consent Order, the Licensee agreed to pay a $500.00 civil penalty.

Case #2009-0289 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist administered nitrous oxide without first obtaining a nitrous oxide permit; failed to appropriately document the administration of the nitrous oxide, and failed to document a dental justification prior to treated a number of teeth. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $10,000.00 civil penalty.

Case #2010-0072 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist administered sedation and then nitrous oxide and failed to appropriately document the administration of the sedation and the nitrous oxide; and failed to document the presence of a perforation of a tooth with gutta percha extruding through the perforation. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $10,000.00 civil penalty.

Case #2009-0153 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to provide proper fixation of a mandibular fracture; failed to maintain adequate maxillomandibular fixation; failed to do adequate radiographic evaluations; and failed to properly position a reconstruction plate during open reduction. In a Consent Order, the Licensee agreed to be reprimanded and to do no open reductions of mandibular jaw fractures until the Licensee does two open reductions of mandibular jaw fractures under the supervision of a Board approved Oral and Maxillofacial surgeon.

Case #2009-0055 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist seated crowns with deficient or open margins on a number of teeth. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0004 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist placed restorations in teeth without documenting a dental justification for the treatment, placed and implant but failed to wait an adequate period of time for osseointegration prior to preparing the implant for a crown, and failed to maintain the CPR/BLS certification necessary for maintenance of a nitrous oxide permit. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2008-0277 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, fabricated a lower removable partial denture that did not meet the acceptable standards of construction, extracted four teeth without documenting a dental justification, failed to document in the patient records obtaining informed consent prior to providing treatment; and failed to remove a mandibular torus prior to construction of a mandibular prosthesis. In a Consent Order, the Licensee agreed to be reprimanded, to pay a $2,000.00 civil penalty, and to complete a three hour course in record keeping.

(continued on page 8)

DISCIPLINARY ACTIONS (Continued from page 7)

Case #2010-0143 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee seated a crown with open margins and then failed to diagnose the open margins that were evident in dental radiographs that were subsequently taken. In a Consent Order, the Licensee agreed make a restitution payment to the patient in the amount of $925.00.

Case #2009-0207 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment; failed to document the dental justification for restoring teeth, prescribing controlled substances, and initiating endodontic therapy; and failed to document the name, quantity, and dosage of controlled substances that were prescribed. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0149 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed diagnose recurrent caries evident on radiographs and seated a crown on a tooth with periapical pathology that was evident on pretreatment radiographs. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0183 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to take radiographs showing the periapical areas of teeth prior to extracting those teeth and failed to document the name, dosage, and amount of antibiotic that the Licensee placed in an extraction site. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0062 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, fabricated upper and lower complete dentures that did not meet the acceptable standards of construction. In a Consent Order, the Licensee agreed to be reprimanded, to make a restitution payment in the amount of $5,700.00 to the patient, and to pay a $5,000.00 civil penalty.

Case #2010-0058 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to take radiographs showing the periapical areas of a tooth prior to extracting the tooth. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2010-0055 The Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist provided dental hygiene services to a patient without the authorization or supervision of a dentist. In a Consent Order, the Licensee agreed to be reprimanded and to provide 40 hours of community service.

Case #2011-0013 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist prescribed controlled substances outside the scope of dentistry for a patient; falsified the patient's dental record in an attempt to justify the prescription; failed to document in the patient records obtaining informed consent prior to providing treatment; and failed to appropriately document the administration of nitrous oxide. In a Consent Order, the Licensee agreed to be reprimanded, to pay a $2,000.00 civil penalty, and to complete a three hour course in record keeping.

Case #2010-0079 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist over-prepared and over-tapered three teeth for crowns; either failed to examine and approved temporary crowns seated by an EFDA assistant before the patient was dismissed or if the Licensee examined and approved the temporary crowns, the patient left the office with crowns that were ill fitting with overhanging margins with excess temporary cement left in the interproximal areas; and failed to maintain the ACLS certification required for maintenance of the Licensee's deep sedation permit. In a Consent Order, the Licensee agreed to be reprimanded and to be assessed for competency in the D-PREP program and complete the recommendations of the assessment.

(continued on page 9)

DISCIPLINARY ACTIONS (Continued from page 8)

Case # 2009-0062 and 2010-0001

The Board issued two Notices of Proposed Disciplinary Action alleging that a dentist induced conscious sedation without first obtaining a conscious sedation permit, failed to obtain informed consent prior to administering conscious sedation; failed to appropriately document the administration of conscious sedation, failed to refer a patient to a specialist, failed to document that informed consent was obtained, failed to document and inform a patient that treatment complications had occurred, seated crowns with open margins, failed to diagnose dental pathology, and provided treatment without any dental justification. In a Consent Order, the Licensee agreed to be reprimanded and to be assessed for competency in the D-PREP program and complete the recommendations of the assessment.

Case #2010-0012 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist placed implants in an area with existing bone over the mandibular canal without first taking a CT scan, and placed implants that were too long in an area with existing bone over the mandibular canal. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $2,000.00 civil penalty.

Case #2010-0106 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, while providing endodontic therapy, failed to diagnose, document, and inform a patient that an instrument was separated and them completed endodontic therapy without fully instrumenting the canals. In a Consent Order, the Licensee agreed to be reprimanded and to not provide any endodontic therapy until the Licensee completed 24 hours of a hands-on course in endodontics or completed three molar endodontic cases under the mentorship of an endodontist.

Case #2010-0212 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist administered moderate sedation on two occasions without documenting the patient's vital signs, that a pulse oximeter was used, the patient's condition upon discharge, and the name of the responsible party to whom the patient was discharged; and failed to maintain current ACLS certification. In a Consent Order, the Licensee agreed to pay a $1,000.00 civil penalty.

Case #2011-0160 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist allowed a dental hygienist to perform duties for which the dental hygienist was not licensed.. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $2,000.00 civil penalty.

Case #2009-0074 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment; provided treatment without a dental justification; and failed to document treatment that was provided. Following an administrative hearing the Board issued a Final Order in which the Licensee was reprimanded, required to complete three hours of continuing education in record keeping, and to reimburse the Board the $4,758.14 costs of the hearing.

Case #2010-0127 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document that informed consent was obtained, failed to accurately document the administration of local anesthetic, failed to diagnose dental pathology, provided treatment without any dental justification, and failed to follow the advice of the patient's cardiologist and administered local anesthetic containing vasoconstrictors . In a Consent Order, the Licensee agreed to be reprimanded and to complete three hours of continuing education courses in record keeping, treating the medically compromised patient, and diagnosis and treatment planning.

Case #2010-0157 The Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, failed to document in the patient records obtaining informed consent prior

(continued on page 10)

DISCIPLINARY ACTIONS (Continued from page 9)

to providing treatment; provided treatment without a dental justification; prescribed medication without a dental justification, failed to document the results of examinations and diagnoses, placed veneers on periodontally involved teeth with a hopeless prognosis, and seated a cantilevered crown on a mesial inclined implant in a patient with an obvious bruxing habit. In a Consent Order, the Licensee agreed to be reprimanded and to make a $5,200.00 restitution payment to the patient.

Case #2010-0235 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist administered nitrous oxide sedation on three occasions without first obtaining a nitrous oxide permit. In a Consent Order, the Licensee agreed to be reprimanded.

Practicing Dentistry Without a License ORS 679.020

Case #2009-0270 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist practiced dentistry without a license between April 1, 2009 and April 11, 2009 and failed to complete a one-hour pain management course. The Licensee failed to request a hearing in the matter so the Board issued a Default Order in which the Licensee was reprimanded and required to pay a $5,000.00 civil penalty.

Case #2010-0263 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist practiced dentistry without a license between April 1, 2010 and April 6, 2010; dentist failed to complete the 40 hours of continuing education for the 2008-2010 license renewal period; on April 6, 2010 made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dentistry in Oregon when the Licensee declared and signed the application certifying that the Licensee had completed the required continuing education; and failed install an amalgam separator. In a Consent Order, the Licensee agreed to be reprimanded and required to pay a $5,000.00 civil penalty.

Practicing Dental Hygiene Without a License ORS 680.020

Case #2010-0085 The Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist practiced dental hygiene without a license on October 1, 2009; failed to complete the 24 hours of continuing education for the 2007-2009 license renewal period; and on October 4, 2009 made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dental hygiene in Oregon when the Licensee declared and signed the application certifying that the Licensee had completed the required 24 continuing education hours. required continuing education hours. In a Consent Order, the Licensee agreed to be reprimanded, to provide 30 hours of community service, and to complete the needed continuing education hours.

Case #2010-0252 The Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist practiced dental hygiene without a license between October 1, 2008 and June 10, 2010. In a Consent Order, the Licensee agreed to be reprimanded, to have the Licensee's dental hygiene license suspended for 30 days, and to pay a $2,500.00 civil penalty.

Case #2011-0160 The Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist practiced dental hygiene without a license between October 1, 2009 and March 18, 2011. In a Consent Order, the Licensee agreed to be reprimanded, to have the Licensee's dental hygiene license suspended for 30 days, and to pay a $2,500.00 civil penalty.

Failure to Complete Continuing Education Required for License Renewal OAR 818-021-0060(1)

Case #2009-0234 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the 40 hours

(continued on page 11)

DISCIPLINARY ACTIONS (Continued from page 10)

of continuing education for the 2005-2007 and 2007-2009 license renewal periods. In a Consent Order, the Licensee agreed to be reprimanded.

Case #2009-0201 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the 40 hours of continuing education for the 2006-2008 license renewal period, failed to maintain a current and valid Health Care Provider BLS/CPR certificate, and on February 27, 2008 made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dentistry in Oregon when the Licensee declared and signed the application certifying that the Licensee had completed the required continuing education hours. In a Consent Order, the Licensee agreed to be reprimanded and to complete the needed continuing education hours.

Case #2010-0264 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the 40 hours of continuing education for the 2006-2008 license renewal period; the Licensee failed to respond to repeated requests from the Board for information; and failed to provide proof of installation of an amalgam separator. In a Consent Order, the Licensee agreed to be reprimanded and to provide 10 hours of community service.

Unprofessional Conduct (Drug and/or Alcohol Abuse) ORS 679.140(2)(e)

Case #2007-0073 The Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist was addicted to, dependent upon, or abused alcohol; treated a patient while under the influence of alcohol; and while under the influence of alcohol arrived at a dental office intending to treat patients. After the Licensee voluntarily entered into an interim Consent Order in which the Licensee agreed to not to practice and treat patients with the Licensee's dental hygiene license pending further order of the Board the Board then reinstated the Licensee's dental hygiene license with a Consent Order after the Licensee agreed to be reprimanded and to fully engage in Board approved treatment and monitoring.

Case #2007-0073 The Board issued an Order of Immediate Emergency License Suspension after the Licensee failed to fully engage in Board approved treatment and monitoring previously agreed to in an Interim Consent Order.

Case #2009-0138 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist was addicted to, dependent upon, or abused alcohol and controlled substances and then falsely answered questions on a dental license renewal application. After the Licensee voluntarily entered into an interim Consent Order in which the Licensee agreed to not to practice and treat patients pending further order of the Board, the Licensee then entered into a Consent Order in which the Board reinstated the Licensee's dental license after the dentist agreed to be reprimanded, to pay a $5000 civil penalty, to provide 40 hours of Board approved community service, and to fully engage in Board approved treatment and monitoring.

Case #2008-0256 Following an Administrative Hearing on the allegation that a dentist was addicted to, dependent upon, or abused alcohol, the Board issued a Final Order suspending the Licensee's dental license until the Licensee completed a residential treatment program.

Case #2008-0256 Upon completion of a residential treatment program, a dentist who was addicted to, dependent upon, or abused alcohol entered into a Consent Order with the Board in which the Licensee's dental license was reinstated, and the Licensee agreed to be reprimanded and to fully engage in Board approved treatment and monitoring.

Case #2005-0117 On July 24, 2009, by an Interim Consent Order, a dentist agreed to not practice dentistry, to not order, store, dispense,

(continued on page 12)

DISCIPLINARY ACTIONS (Continued from page 11)

and/or prescribe any controlled drugs pending further order of the Board, on alleging that a dentist was addicted to, dependent upon, or abused alcohol and controlled substances and then falsely answered questions during a Board investigation and on a dental license renewal application.

Case #2005-0117 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist was addicted to, dependent upon, or abused alcohol and controlled substances and then falsely answered questions during a Board investigation and on a dental license renewal application. After the Licensee entered into an Interim Consent Order in which the Licensee agreed to not practice dentistry and to not order, store, dispense, and/or prescribe any controlled drugs pending further order of the Board, the Licensee then entered into a Consent Order in which the Board reinstated the Licensee's dental license after the dentist agreed to be reprimanded, to have the Licensee's dental license be suspended for six months, to then only practice for 15 hours per week, to provide 40 hours of community service, to pay a $5,000.00 civil penalty, to complete three hours of continuing education in record keeping, and to fully engage in Board approved treatment and monitoring.

Case #2009-0277 The Board issued an Order of Immediate Emergency License Suspension after a dentist admitted that the Licensee was addicted to, dependent upon, or abused controlled substances.

Case #2009-0277 After a dentist was issued an Order of Immediate Emergency License Suspension after the Licensee admitted being addicted to, dependent upon, or abused controlled substances, the Licensee agreed in an Interim Consent Order with the Board to obtain an evaluation for a substance use disorder diagnosis and to fully engage in the recommended treatment regimen.

Case #2011-0082 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist falsified a prescription to obtain hydrocodone for the Licensee's own use. In a Consent Order, the Licensee agreed to be reprimanded and to provide 40 hours of community service.

Case #2009-0138 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist was addicted to, dependent upon, or abused alcohol and controlled substances and then falsely answered questions on a dental license renewal application. After the Licensee voluntarily entered into an interim Consent Order in which the Licensee agreed to not to practice and treat patients pending further order of the Board, the Licensee then entered into a Consent Order in which the Board reinstated the Licensee's dental license after the dentist agreed to be reprimanded, to pay a $5000 civil penalty, to provide 40 hours of Board approved community service, and to fully engage in Board approved treatment and monitoring.

Case #2011-0088 Following an investigation, a dental hygienist entered into an Interim Consent Order with which the Licensee agreed to not practice dental hygiene pending further order of the Board.

Unprofessional Conduct (Discipline in Another State) ORS 679.140(2)(h)

Case #2008-0185 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist was disciplined by the State of Washington Department of Health Dental Quality Assurance Commission and entered a Stipulated Findings of Fact, Conclusions of Law and Agreed Order in Case Docket No. 06-06-A-1043DE making findings that the Licensee provided care below the standard of care for the State of Washington. In a Consent Order, the Licensee agreed to complete at least three hours of continuing education in record keeping, to comply with the provisions of the Agreed Order in the Licensee's disciplinary action in the State of

(continued on page 13)

DISCIPLINARY ACTIONS (Continued from page 12)

Washington, and to not provide conscious sedation in Oregon until the Licensee completed the conscious sedation skill assessment required by the State of Washington.

Case #2010-02695 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that a dentist's license was revoked by the Department of Consumer Affairs for the Dental Bureau of California, Health Dental Quality Assurance Commission State of California. In a Consent Order, the Licensee agreed to resign the Licensee's Oregon dental license and to never reapply for an Oregon Dental License.

Violation of an Order Issued by the Board ORS 679.140(1)(d)

Case #2006-0200 On October 20, 2006, by a Consent Order, a dental hygienist agreed, in part, to provide documentation of completion of 24 hours of continuing education for the 2005 – 2007 and 2007 – 2009 licensing periods. The licensee subsequently failed to provide documentation of completion of the continuing education requirements. In a Consent Order, the Licensee agreed to be reprimanded and to pay a $1,000.00 civil penalty.

Prohibited Practices (Making False Written or Oral Statements) ORS 679.170(5)

Case #2009-0283 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment; fabricated alterations to a dental record and then destroyed the original record, attempted to deceive the Board in a written response, to the Board, failed to complete the continuing education required for renewal of the Licensee's nitrous oxide permit, and made an untrue statement on the Licensee's License and Permit Renewal Application form to practice dentistry in Oregon for the April 1, 2008 – March 31, 2010 licensing period when the Licensee declared and signed the Licensee's application on February 13, 2008, certifying that the Licensee had completed the continuing education requirements for renewal of the nitrous oxide permit. In a Consent Order, the Licensee agreed to be reprimanded, to complete three hours of continuing education courses in record keeping and risk management, and to pay a $5,000.00 civil penalty.

Case #2009-0283 The Board issued a Notice of Proposed Disciplinary Action alleging that a dentist that a dentist failed to document in the patient records obtaining informed consent prior to providing treatment; fabricated alterations to a dental record and then destroyed the original record, attempted to deceive the Board in a written response, to the Board, failed to complete the continuing education required for renewal of the Licensee's nitrous oxide permit and also failed to complete the 40 hours of continuing education needed for license renewal, and made an untrue statement on the Licensee's License and Permit Renewal Application form to practice dentistry in Oregon for the April 1, 2009 – March 31, 2011 licensing period when on January 27, 2009, the Licensee declared and signed the Licensee's application certifying that the Licensee had completed the continuing education requirements for renewal of the nitrous oxide permit and the dental license. In a Consent Order, the Licensee agreed to be reprimanded, to complete three hours of continuing education courses in record keeping and risk management, and to pay a $5,000.00 civil penalty.

Failure to File a State Income Tax Return or Pay State Income Tax ORS 305.385

Case #2011-0087 Following a request by the Oregon Department of Revenue to suspend the license of a dentist, the Board issued a Notice of Proposed License Suspension. An administrative hearing was held and the Board issued a Final Order suspending the Licensee's dental license pending further order of the Board. ■

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The Board office is open from 7:30 a.m. to 4:00 p.m., Monday through Friday, except State and Federal holidays.
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FAREWELL TO BOARD MEMBER

We wish to extend a great big "Thank you" to Dr. Rodney Nichols of Portland for his eight plus years of dedicated service to the Board of Dentistry and the citizens of Oregon. Dr. Nichols served in many different roles including President of the Board and a longtime Chair of the OBD Anesthesia Committee.

Dr. Nichols' expertise, as well as the regular delivery of popcorn and candy from the candy store located near his office in Milwaukie, will be missed by his fellow Board members and staff and we wish him well in his future endeavors. ■

QUESTIONS? *Call the Board office at 971-673-3200 or e-mail your questions to us at information@oregondentistry.org.*

SCHEDULED BOARD MEETINGS

2012

- April 6, 2012
- June 1, 2012
- August 3, 2012
- October 5, 2012
- December 14, 2012

NEW BOARD MEMBERS

Julie Ann Smith, D.D.S., M.D., of Happy Valley joined the Board in June of 2011 following her appointment by Governor Kitzhaber and confirmation by the Oregon State Senate. Dr. Smith has a BA degree in Biology from Mount Holyoke College and received her D.D.S. degree from Columbia University and her M.D. degree from the University of Pittsburgh School of Medicine.

She served as an Oral and Maxillofacial Surgeon at Walter Reed Medical Center from 2001 to 2008 leaving with the rank of Lt. Colonel. She is currently an Assistant Professor and Pre-doctoral Director, Department of Oral and Maxillofacial Surgery, at the Oregon Health and Science University.

She is a member of the American Association of Oral and Maxillofacial Surgeons, the American Board of Oral and Maxillofacial Surgeons, and the American Dental Association.

Dr. Smith has served a Board Examiner for the American Board of Oral and Maxillofacial Surgeons and a site visitor for the Commission on Dental Accreditation.

She has published numerous articles and publications and presented many scientific publications during her career.

Alton Harvey, Sr. of Beaverton, joined the Board of Dentistry as the second Public Member in June of 2010, following his appointment by then Governor Theodore Kulongoski and confirmation by the Oregon Senate.

Mr. Harvey is the fifth of nine children born into a family of sharecroppers in Georgia. His family moved to Chicago, Illinois where he received his education and worked many years as a commercial truck driver. He moved to Beaverton from Chicago, IL in 1995.

Mr. Harvey is married and they recently celebrated their 50th wedding anniversary.

Mr. Harvey has been active in many community, civic, church and neighborhood associations and has authored a book titled *Freedom an Optical Illusion*, which was published in 2007, along with many newspaper articles. ■

OBD Rule Changes Effective November 15, 2011

The following are brief descriptions of some of the Administrative Rules that were created, amended, adopted, or repealed by the OBD on October 28, 2011 and became effective November 15, 2011. These rule changes can be found on the OBD Web site at http://www.oregon.gov/Dentistry/regulations.shtml.

The OBD adopted 818-005-0000 through 818-005-0045 to allow for fingerprinting and criminal background checks to be conducted on OBD Staff.

The OBD amended 818-001-0087 Fees, to allow the Board to increase the Biennial License fees for Dentists and Dental Hygienists, to eliminate the fees for Limited Access Permit Dental Hygienists, and to create a fee for Expanded Practice Dental Hygienists that was effective July 1, 2011.

The OBD amended 818-015-007 Advertising, to simplify the rules and to reflect changes in the regulations.

The OBD amended 818-021-0017 Application to Practice as a Specialist, to allow any Board approved examination to qualify for a Specialty License.

The OBD amended 818-021-0025 Application for License to Practice Dental Hygiene Without Further Examination, to reflect the type of examination required.

The OBD amended 818-021-0060 Continuing Education - Dentists and 818-021-0070 Continuing Education – Dental Hygienists, to clarify that continuing education credit for volunteer pro bono dental services must be in Oregon.

The OBD amended 818-026-0060 Moderate Sedation Permit, to allow for an additional course to meet the life support requirements.

The OBD amended 818-026-0065 Deep Sedation, to require that an electrocardiograph monitor (ECG) be required when Deep Sedation is administered and the patient's heart rhythm shall be continuously monitored.

The OBD amended 818-026-0070 General Anesthesia Permit, to require an electrocardiograph monitor (ECG) and continuous monitoring of a patient's heart rhythm when General Anesthesia is administered.

The OBD amended 818-035-0065 Limited Access Permits and 818-035-0100 Record Keeping, to reflect the changes made by Senate Bill 738 (Chapter 716 2011 Oregon Laws) and to clarify duties. ■

2011 Legislative Session

Senate Bill 738, Oregon Laws Chapter 716 (2011 Laws) changed the name of Limited Access Permit (LAP) Dental Hygienists to Expanded Practice Permit (EPP) Dental Hygienists.

Expands the current populations that Expanded Practice Permit Dental Hygienists can treat without the supervision of dentists to include patients whose income is less than the federal poverty level and other populations the Board determines are underserved or lack access to dental hygiene services.

Allows Expanded Practice Permit Dental Hygienists who have entered into a collaborative agreement with an Oregon licensed dentist to:

(a) Administering local anesthesia;

(b) Administering temporary restorations without excavation;

(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; and

(d) Overall dental risk assessment and referral parameters. ■

OREGON BOARD OF DENTISTRY
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IT'S THE LAW!

You must notify the OBD within 30 days of any change of address. An on-line Address Change Form is on the OBD's Web site at **www.oregon.gov/Dentistry**. *All address changes must be made in writing by fax, mail or e-mail.*

Our Mission: *The mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care.*

OREGON BOARD OF DENTISTRY DENTAL LICENSE RENEWAL NOTIFICATION

Renew Online:

To access your renewal online, use the link below and enter your last name, license number and the last four digits of your social security number.

Please go to www.oregon.gov/dentistry and select the renewal link.

If you have any questions, please contact the OBD at 971-673-3200.

Remember:

Your dental license expires on March 31, 2012.
If your license has not been renewed by March 31, you cannot practice.