



PRESIDENT'S MESSAGE

by Jill Mason, M.P.H., R.D.H.,
President 2009-2010



President of the Oregon Board of Dentistry – I suspect it's not something anyone aspires to when deciding to go to dental or dental hygiene school. I suspect also it is rarely on any licensee's list of "Things to do before I retire."

Involvement on Board Committees? Maybe that comes to mind for some as a service to the profession. It is important to be involved in the profession, know the regulations, and keep abreast of the changes that are coming. And there are changes coming.....

As I begin my second term on the Board and my term as President, it is a good time to reflect on both the past and future. It is amazing how quickly time passes, and how rewarding it is to think of playing a role in assuring Oregonians receive the highest possible quality oral health care. That is the Mission of the Oregon Board of Dentistry, and mirrors my own public health background. I view the Board as one piece of a large puzzle that when we all are pieced together,

we can achieve a picture of oral health for and protect all of our citizens. It requires both private and public health practitioners, future practitioners, the Board, the legislature, and many other health agencies and partners to complete the picture.

Each year, members of all Boards of Dentistry throughout the country meet to discuss issues common among all of the states. Every year I return from that meeting reminded that Oregon is a great place to practice! Many of the issues other states are struggling with have long ago been successfully resolved in Oregon. We continue to be looked upon nationally as a leader in this arena. Can you believe local anesthesia administration by dental hygienists is still prohibited in many states, because it would be a danger to the public? I am proud to report at these meetings that Oregon professionals routinely work collaboratively to discuss innovative solutions and how to maintain safety and achieve access to care for Oregonians. This is not the case in many states.

Our rules process is just that, a process. Not only that, it is an open public process. The Board meetings, except for the disciplinary process with cases, are public meetings, as are the various committee meetings of the Board. We recently completed a legislative session, and there are several items that will affect our Board and your license and profession. Read the article later in this newsletter for an update on the legislative changes the Board will be addressing very soon.

It takes all of us, the public through the legislative process, the Board to interpret and enforce the Statutes and Rules, collaborative discussions about solutions, participation on Board committees, and providing input at public hearings. Let's all do our part to continue Oregon's leadership in assuring that the citizens of Oregon receive the highest possible quality oral health care.

Maybe one day you will be the one writing this column..... ■

***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.*

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THE LIGHT IS GROWING DIM

by Patrick D. Braatz, Executive Director



The last time I told you that I could see the light at the end of the tunnel; now I am concerned that this light may be growing dim!!!

The 2009 Oregon Legislative Session has ended, but it left many

changes that will affect the Oregon Board of Dentistry (OBD) and the Dental/Dental Hygiene professions.

On a positive note, the Legislature did approve the OBD's 2009 – 2011 Biennial Budget which included some modest application, license and renewal fee increases. These increases are the first since 1999 and are mainly what we call "pass throughs," meaning that although the OBD will be collecting these monies, they will actually be paid to other state or national government agencies for services that the OBD purchases.

House Bill 2118, Oregon Laws Chapter 756 (2009 Laws) increased the size of the OBD from 9 to 10 members with inclusion of an additional public member. This was after much testimony against the original proposal which would have been to remove three professional members (two dentists and one dental hygienist and replace them with three public members). This legislation will also require the OBD, along with all other health regulatory boards, to prepare periodic reports regarding the licensing, monitoring and investigative activities of the Board and submit them to the Board and the Governor; the boards will then undergo a peer review audit of those reports. It also removed the Boards' power to fire or hire an Executive Director without the approval of the Governor.

House Bill 2059, Oregon Laws Chapter 536 (2009 Laws) requires all Health Care Providers, as defined by Oregon law, to report any convictions of a misdemeanor or felony to the Board as well as any arrest for a felony within 10 days of the arrest or conviction. Health Care Providers also must report to their respective boards if they witness any other Health Care Provider commit "Prohibited Conduct" and/or "Unprofessional

Conduct" as defined under Oregon Law or they could be subject to disciplinary action by their respective boards for failure to do so.

House Bill 2345, Oregon Laws Chapter 697 (2009 Laws) requires that all Health Care Regulatory Boards that have confidential impairment programs cease operation of those programs and they must be housed and placed under the control of the Oregon Department of Human Services on or before July 1, 2010.

On the horizon, the Oregon Legislature also wants to review the Oregon law that allows only dentists, with some legislative exemptions, to own a dental practice. It is felt that this law should be changed to open up the issue of ownership to non-dentists.

Look for other articles in this Newsletter on legislation that was recently passed and that the OBD is working on implementing, either through Administrative Rules or Board Policies.

I urge you to stay informed and to reach out to your Representatives and Senators and tell them your feelings on any previously passed and proposed legislation that will affect the OBD, as well as the practice of Dentistry and Dental Hygiene.

Please feel free to contact me with your questions, concerns or comments at (971) 673-3200 or by email Patrick.Braatz@state.or.us or by stopping by the OBD office in downtown Portland. ■

BOARD MEMBERS

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Term expires 2013

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Vice-President
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Term expires 2011

Jonna Hongo, DMD
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Term expires 2012

David Smyth, BS, MS
Public Member, Wallowa
Term expires 2012

Brandon Schwindt, DMD
Tigard
Term expires 2013

Darren Huddleston, DMD
Grants Pass
Term expires 2013

OBD RULE CHANGES EFFECTIVE NOVEMBER 1, 2009

The following are brief descriptions of some of the Administrative Rules that were amended, adopted or repealed by the OBD on September 25, 2009 and became effective November 1, 2009. These rule changes can be found on the OBD Web site at <http://www.oregon.gov/Dentistry/regulations.shtml>.

The OBD amended 818-001-0000 Notice of Proposed Rule Making, to update the correct names of some entities and to delete entities who receive Notices of Proposed Rulemaking.

The OBD amended 818-001-0087 Fees, to publish the correct fees for applicants and licensees that were recently adopted by the Oregon Legislature and signed into law by the Governor.

The OBD adopted 818-001-0090 Board Member Compensation, which allows the Oregon Board of Dentistry to set by rule the compensation for Board members, in addition to the current Oregon Statute on Board member compensation that was recently adopted by the Oregon Legislature and signed into law by the Governor.

The OBD amended 818-021-0012 Specialties Recognized, to update the title of a dental specialty that is defined by the American Dental Association.

The OBD amended 818-021-0025 Application for License to Practice Dental Hygiene Without Further Examination, that would allow a dental hygienist to count the teaching of clinical dental hygiene toward the 3,500 hour requirement for Licensure Without Further Examination.

The OBD amended 818-021-0050 Community Health Experience for Dental and Dental Hygiene Students, to allow any Dental Hygiene student to participate in clinical studies as a result of a new law removing the word “full-time” adopted by the Oregon Legislature and signed into law by the Governor.

The OBD amended 818-021-0070 Continuing Education – Dental Hygienists, to implement the changes regarding continuing education for Limited Access Permit Dental Hygienists that are a result of a new law adopted by the Oregon Legislature and signed into law by the Governor.

The OBD amended 818-035-0030 Additional Functions of Dental Hygienists, to clarify the

prescription authority for dental hygienists and to allow dental hygienists to perform all aspects of teeth whitening procedures.

The OBD amended 818-042-0070 Expanded Function Dental Assistants (EFDA), to allow Expanded Function Dental Assistants to perform all aspects of teeth whitening procedures.

The OBD amended 818-042-0080 Certification – Expanded Function Dental Assistant (EFDA) to add a provision for certification of Expanded Function Dental Assistants regarding teeth whitening procedures. ■

2010 DENTAL RENEWAL ONLINE

January of 2010 will mark the beginning of a new process for the renewal of Dental and Dental Hygiene licenses in Oregon.

Shortly after January 15, 2010, Oregon dentists whose licenses expire on March 31, 2010 will receive a postcard from the Oregon Board of Dentistry (OBD) informing them that their online license renewal is ready to be accessed on the OBD Web site www.oregon.gov/dentistry.

If you do not receive a postcard by January 31, 2010, you should contact the OBD to inform them that you have not received your renewal postcard.

This Web site will include instructions on how to complete your online renewal and allow you to pay your renewal fee with a credit card (Visa or MasterCard).

If you are unable to renew online, please contact the OBD at 971-673-3200.

Those Licensees who have been selected for an audit should have received an audit letter and will continue to submit their Continuing Education Audit information in a paper form. Audit notices were mailed the first week in December 2009.

If you have questions about the new online license renewal process, please feel free to contact the OBD office at 971-673-3200 or by email at information@oregondentistry.org. ■



2009 LEGISLATIVE SESSION WRAP-UP

House Bill 2058, Oregon Laws Chapter 535 (2009 Laws)

Standardizes qualifications for health regulatory board members such as qualifications for professional members, who can suggest names for nomination, qualifications for public members, all board members serve at the pleasure of the Governor, removal from office for excessive absences, requires that each board have at least two public board members.

House Bill 2658, Oregon Laws Chapter 147 (2009 Laws)

This new law requires that dental technicians, upon request of a dentist or patient, provide information about the location where oral prosthetic devices were manufactured.

House Bill 3204, Oregon Laws Chapter 582 (2009 Laws)

This law requires that the Board develop an additional pathway for the eligibility to receive a Limited Access Permit (LAP) for a dental hygienist that includes at least 500 hours of clinical practice, which can include hours performed in a dental hygiene educational program. It will also allow LAP Dental Hygienists to work with

patients in hospitals, medical clinics, medical offices or offices staffed by nurse practitioners, physician assistants or midwives. It further allows LAP Dental Hygienists to place soft denture relines and take radiographs without the general supervision of a dentist.

Senate Bill 117, Oregon Laws Chapter 223 (2009 Laws)

This legislation includes an exemption for institutions of higher education to own a dental clinic.

Senate Bill 355, Oregon Laws Chapter 799 (2009 Laws)

allows for the creation of a Prescription Drug Monitoring Program to help stop drug seekers. The program can be used by all prescribers of controlled substances and is similar to a program available in 34 other states and requires that the prescribers pay for this program through an increase of \$25.00 per year on license renewal fees. We are hopeful that when this program is up and running, that dentists won't be scammed into providing drugs to those who are simply trying to abuse the system, rather than those patients that really need these medications. ■

DISCIPLINARY ACTIONS TAKEN BETWEEN OCTOBER 1, 2008 AND JULY 31, 2009

Unacceptable Patient Care ORS 679.140(1)(e)

Case #2008-0082 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, between April 1, 2005 and March 31, 2007, failed to complete the required 40 hours of continuing education and on March 1, 2007, made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dentistry in Oregon for the April 1, 2007 – March 31, 2009 licensing period, when the Licensee declared and signed the Licensee's application certifying that between April 1, 2005 through March 31, 2007, the Licensee had completed the required 40 hours of continuing education required for renewal of the Licensee's dental license. Aware of the Licensee's right to a hearing, and wishing to resolve these matters, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to complete the continuing education hours not completed for the April 1, 2005 – March 31, 2007 licensing period, to provide 10 hours of Board approved non-reimbursed community dental service, and to pay a \$1,000.00 civil penalty.

Case #2008-0230 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, on four occasions, failed to document in the patient records "PARQ" or its equivalent after obtaining oral informed consent prior to providing treatment; on two occasions, while administering central nervous system sedation, failed to take and document vital signs in the patient's record and failed to document in the patient's record the patient's condition upon discharge; wrote a prescription for Percocet but did not document the amount and strength of the medication and did not document a dental justification for writing the prescription; failed to diagnose and document endodontically unfilled MB and DB roots in tooth #3 and a perforation into the furcation

of the tooth that were all evident on periapical radiographs; wrote a prescription for 20 tablets of Vicodin ES but did not document a dental justification for writing the prescription. The Licensee failed to request a hearing in a timely manner so the Board issued a Default Order in which the Licensee was reprimanded and ordered to pay the patient a restitution amount of \$3,995.00.

Case #2007-0265 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist between January 1, 2005 and April 30, 2007, permitted an unlicensed dentist to perform duties for which the dentist was not licensed or certified to do. Aware of the Licensee's right to a hearing, and wishing to resolve these matters, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to pay a civil penalty in the amount of \$6,000.00. The penalty will be stayed provided that the Licensee presents to the Oregon Board of Dentistry, within one year, a written workable plan to legally manage the issue of foreign trained dentists as faculty and to provide a written plan to allow post-graduate dentists dental experience prior to licensure. Written progress reports on implementation of said plans shall be provided to the Board every three months.

Case #2009-0013 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, on five occasions, failed to document in the patient records "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; placed restorations in teeth #s 14 – B and 18 - O and did not document a dental justification for placing the restorations; placed restorations in teeth #s 2 – M and 14 – OL and did not document a dental justification for placing the restorations; between April 1, 2006 and March 31, 2008 failed to complete the 40 hours of continuing education required for that

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DISCIPLINARY ACTIONS (Continued from page 5)

licensing period; and on March 21, 2008, made an untrue statement on the Licensee's application for renewal of the Licensee's license 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 certifying that between April 1, 2006 and March 31, 2008 the Licensee had completed the 40 hours of continuing education hours required for that two year licensing period. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay a \$1,000.00 civil penalty.

Case #2007-0179 and #2008-0137

Based on the results of two investigations, the Board issued two Notices of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records a diagnosis to justify initiating endodontic therapy in tooth #11; documented in the patient records that the Licensee did a pulpotomy in tooth #11, and then billed the patient \$186.00 for a pulpotomy utilizing CDT Code D3220 (therapeutic pulpotomy), when in fact, the Licensee initiated endodontic therapy by doing a pulpectomy in the tooth; documented in the patient records that the Licensee administered Triazolam .25 mg @ 7:30, .125 mg @ 9:15, and .125 mg @ 11:00, yet the Licensee's billing records showed that the Licensee billed the patient \$1,000.00 twice, utilizing CDT Code D9241 (IV conscious sedation/analgesia – first 30 minutes) although there was no documentation that IV sedation was done at the appointment; documented in the patient records that the Licensee did a RCT fill – Thermafil – 1 canal in tooth #11, and the Licensee's billing records showed that the Licensee billed the patient \$559.00, utilizing CDT Code D3310 (anterior endodontic therapy), although the Licensee already erroneously billed the patient \$186.00 for a pulpotomy utilizing CDT Code D3220 (therapeutic pulpotomy), and failed to credit the patient for that erroneous billing; documented in the patient records that the Licensee did an indirect pulp cap on tooth #29, yet the Licensee's billing records

showed that the Licensee billed the patient \$81.00 for that procedure, utilizing CDT Code D3110 (pulp cap - direct) instead of billing the patient \$59.00, utilizing CDT Code D3120 (pulp cap – indirect); failed to document in the patient records a diagnosis to justify retreating teeth #s 6, 7, 12, and 14; failed to document in the patient records a diagnosis to justify temporarily cementing the crown on tooth #9; failed to document in the patient records a diagnosis to justify retreating teeth #s 6, 7, and 9; failed to document in the patient records periapical pathology in tooth #9 that was evident in radiographs; allowed a dental assistant without radiographic proficiency certification from the Board to place x-ray films in patient's mouth prior to the Licensee exposing the films; failed to document in the patient records the name of the material used to restore tooth #15 – O; failed to document in the patient records the name of the cementation material used to permanently cement crowns; failed to document in the patient records that impressions were taken or that a temporary crown was seated on tooth #8; failed to document in the patient records what treatment was provided to the retained root of tooth #8 or that impressions were taken and a temporary crown was seated on tooth #7; seated a permanent crown with overhanging margins on tooth #31; and seated a cantilevered bridge replacing tooth #8 on tooth #7, an abutment tooth with an inadequate crown-root ratio to support the bridge. Aware of the Licensee's right to a hearing, and in order to resolve these two matters, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay a \$3,000.00 civil penalty.

Case #2008-0236 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to remove existing caries prior to restoring teeth #s 3 – MOB, 4 – MOD, 12 – O, 14 – DO, 18 – O, 19 – O, and 21 – O; and failed to maintain records of the Licensee's successful completion of the 40 hours of continuing education required for the April 1, 2006 and March 31, 2008 time period. Aware of the Licensee's right to a hearing, and in order to resolve this matter,

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the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay the patient a restitution amount of \$3,995.00.

Case #2009-0036 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist while treating patients between October 29, 2002 and October 13, 2008, allowed dental assistants under the Licensee's supervision to start the administration of nitrous oxide to the Licensee's patients. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay a \$1,500.00 civil penalty.

Case #2009-0027 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist on seven occasions failed to document in the patient records "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; failed to diagnose and document periapical pathology associated with tooth #14 that was evident on the radiographs; failed to diagnose and document recurrent caries under the distal margin of the crown on tooth #14 that was evident on the radiographs that were taken; and failed within 10 days after demand made by the Board, to respond to the Board's written request to provide the original records and a written narrative response to the allegations made by the complainant in Case 2009-0027. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay a \$1,000.00 civil penalty.

Case #2008-0301 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist perforated the root of tooth #19 while providing endodontic therapy and failed to inform the patient and document the incident in the patient

records, and then seated a crown with a deficient or open margin on tooth #19. The Licensee failed to request a hearing in a timely manner so the Board issued a Default Order in which the Licensee's license to practice dentistry was revoked.

Case #2008-0165 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist reused and allowed persons under the Licensee's supervision to reuse disposable gloves. Aware of the Licensee's right to a hearing, and wishing to resolve these matters, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and pay a \$1,000.00 civil penalty.

Case #2008-0118, #2008-0143, #2008-0181, #2008-0189, #2008-0197, and #2008-0281 On January 2, 2009, by an Interim Consent Order, the dentist agreed not to perform any indirect restorations, pending further order of the Board; to provide the Board with the name, address, and phone number of each health care provider of all physical, psychiatric, or psychological health care providers who treated Licensee between 2000 and Present; to waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining suitability to practice dentistry, and shall execute any waiver or release upon request of the Board; to direct all health care providers, who treated Licensee between 2000 and Present, to promptly respond to any Board inquiry and provide documentation requested by the Board, regarding any treatment provided to Licensee between 2000 and Present; within 72 hours, to advise the Board of any change of physical, psychiatric, or psychological health care provider not previously identified to the Board; and provide the Board with a list of patients, including a description of the treatment provided, that were treated between January 1, 2008 and Present.

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DISCIPLINARY ACTIONS (Continued from page 7)

Case #2008-0118, #2008-0143, #2008-0181, #2008-0189, #2008-0197, and #2008-0281 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, while treating patient RB, failed to diagnose and document periapical pathology on one tooth; failed to take and document vital signs when administering central nervous system sedation; failed to document dental justification for preparing 19 teeth for crowns; failed to extract the roots of two teeth; falsely documented placement of a post in a tooth when he did not; seated four crowns with open margins; failed to document dental justification for TENS therapy; failed to document dental justification for a restoration on one tooth; and failed to document preparing four teeth for bridge abutments, taking impressions, and placing temporary restorations on the teeth; while treating patient DP, failed to take and document vital signs when administering central nervous system sedation; and failed to diagnosis and document open contacts between crowns on multiple teeth which were evident on radiographs; while treating patient JP, failed to document PARQ or its equivalent for treatment plans; failed to document placement of temporary crowns, taking impressions, use of laser or retraction cord, and permanent cementation of crowns; failed to document dental justification for preparing 30 teeth for crowns and veneers; and permanently cemented restorations with open margins on nine teeth; while treating AM, prepared 22 teeth without dental justification and did not document the type of restorations for the 22 teeth; failed to document vital signs, and level and duration of use when administering nitrous oxide; permanently cemented porcelain restorations with open margins on seven teeth; twice failed to document use of a laser; and twice failed to document use of local anesthetic; and while treating patient RR, prepared 31 teeth without dental justification; failed to document use of a laser or retraction cord and the taking of impressions; failed to document vital signs and duration of use when administering nitrous oxide; and permanently cemented porcelain restorations with

open margins, open contacts, and/or overhanging margins on eleven teeth. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee's dental license was reinstated without restrictions, the Licensee agreed to be reprimanded, to pay \$28,847 in restitution to patient RB, to pay \$15,033 in restitution to patient RR, to pay \$11,086 in restitution to patient JP, and to pay \$8,960 in restitution to patient AM.

Case #2009-0100 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document in the patient records all of the diagnostic tests performed while attempting to diagnose the source of an infection in the patient's upper right jaw and failed to utilize all appropriate diagnostic tools, including dental radiographs and a gutta percha point, when attempting to diagnose the source of an infection in the patient's upper right jaw. Aware of the Licensee's right to a hearing, and wishing to resolve these matters, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed be reprimanded and to make a restitution payment of \$830.00.

Case #2008-0270 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to evaluate the periapical status of tooth #3 prior to permanently cementing a crown on that tooth and failed to provide a patient with legible copies of the patient's records within 14 days of receipt of the patient's February 5, 2008 written request for the record copies. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to make a restitution payment of \$1,050.00.

Case #2008-0262 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to diagnose and document periapical

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DISCIPLINARY ACTIONS (Continued from page 8)

pathology associated with tooth #21 that was evident on radiographs taken on that date; failed to document in the patient records “PARQ” or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; failed to diagnose and document that there was an open distal margin on the crown on tooth #3 that was evident on radiographs; and failed to document in the patient records that a core buildup was done and then a porcelain crown was seated on tooth #3. Aware of the Licensee’s right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and make a restitution payment of \$6,851.00.

Practicing Dentistry Without a License ORS 679.020

Case #2008-0251 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist practiced dentistry without a license between April 1, 2008 and April 10, 2008. Aware of the Licensee’s right to a hearing, and in order to resolve this matter, the Licensee voluntarily entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to provide 40 hours of Board approved community service within one year of the effective date of the Order.

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

Case #2008-0122 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the 40 hours of continuing education for the 2005-2007 license renewal period; on March 12, 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 between April 1, 2005 through March 31, 2007; and permitted an unlicensed dental hygienist to practice dental hygiene from October 1, 2007 to November 28, 2007. Aware of the Licensee’s right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to pay a \$1,000.00 civil penalty.

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

Case #2007-0073 Based on the results of an investigation, 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. Aware of the Licensee’s right to a hearing, and wishing to resolve these matters, the Licensee voluntarily entered into an interim Consent Order in which the Licensee agreed not to practice and treat patients with the Licensee’s dental hygiene license pending further order of the Board and prior to reinstatement of the Licensee’s dental hygiene license, Licensee will undergo a substance abuse assessment with a Board approved entity and fully engage in Board approved recommended treatment.

Case #2009-0138 On January 30, 2009, by an Interim Consent Order, the dentist agreed to not practice dentistry; to not order, store, dispense, and/or prescribe any controlled drugs pending further order of the Board; and that this document will be a public record when it is entered into by the Board.

Case #2005-0117 On July 24, 2009, by an Interim Consent Order, the dentist agreed to not practice dentistry; to not order, store, dispense, and/or prescribe any controlled drugs pending further order of the Board; and that this document will be a public record when it is entered into by the Board.

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DISCIPLINARY ACTIONS (Continued from page 9)**Unprofessional Conduct (Discipline in Another State) ORS 679.140(2)(h)**

Case #2009-0102 Based on the results of an investigation, 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. 07-05-A-1099DE making findings that the Licensee provided care below the standard of care for the state of Washington. In that stipulation, specific findings were made as to the Licensee's failure to properly diagnose and/or treat the patient's initial presenting condition(s); failure to adequately plan and/or write the treatment plan or to discuss the patient's condition with sufficient specificity, note problems, record progress and guard against treatment plan discrepancies; failure to discuss with the patient and family and/or record in the patient's chart that the Licensee discussed the risks and benefits of treatment and potential complications; and failure to properly monitor or modify the treatment to the patient, causing the patient to suffer severe root resorption on tooth #s 7, 8, 9, 10 and 13, requiring upper and lower quadrant bone grafts and implants to replace teeth with severe root resorption. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be restricted until May 2018, unless otherwise released from this restriction in the state of Washington, from practicing Orthodontics in the state of Oregon and the Licensee is required to complete the requirements as set forth in the Stipulated Findings of Fact, Conclusions of Law and Agreed Order by the state of Washington, Department of Health, Dental Quality Assurance Commission No. M2007-54638 Docket No, 07-05-A-1099DE issued on May 2, 2008.

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

Case #2007-0109 On August 6, 2007, by a Consent Order, Licensee agreed, in part, to "no longer provide dental treatment to any family members." and to "immediately begin using pre-numbered prescription pads for prescribing controlled substances." On January 5, 2009, a pharmacist advised the Board that on January 3, 2009, she received a prescription for Duragesic 100 mcg/hour patches and Tramadol for JJ, a 71-year old woman, ordered by Licensee; on January 5, 2009, Licensee presented at the pharmacy to pick up the prescriptions and advised the pharmacist JJ was his mother, but the attending pharmacist refused to fill the prescription; the pharmacist provided the Board with copies of the subject prescriptions that revealed the prescription for Duragesic was written on other than a pre-numbered triplicate prescription system; examination of Licensee's dental records for patient JJ, Licensee's mother, disclosed that Licensee failed to document dental justification for root canal procedures, that radiographs were taken, which teeth were treated, dental justification for preparing tooth #18 for a crown, PARQ, dental justification for a restoration placed in tooth #15, justification for prescribing antibiotics, and documentation of vital signs, amount of nitrous oxide administered, and the patient's condition at discharge; Licensee claimed no knowledge of whether patient JJ was, or was not, opioid tolerant, and that Licensee believed JJ's husband, a retired physician, could make the final determination of whether to administer the Duragesic, and justified the 100 mcg/hour dosage because he thought JJ could cut the Duragesic patches in small pieces and apply them. Information for Duragesic revealed the drug was available in 12, 25, 50, 75, and 100 mcg/hour dosages; should only be used for patients receiving opioid therapy and who are opioid tolerant; use without opioid tolerance risked fatal overdose due to respiratory failure; elderly patients should not be started on a Duragesic dosage greater than 25 mcg/hour; and the Duragesic patch should not be cut

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DISCIPLINARY ACTIONS (Continued from page 10)

or damaged as controlled delivery could not be possible which can lead to a rapid absorption of a fatal dose of Fentanyl. The Board issued an Order of Immediate Emergency License Suspension on January 30, 2009.

Case #2007-0109 Based on the results of an investigation, on March 24, 2009, the Board issued a Notice of Proposed Disciplinary Action alleging Licensee treated his mother, failed to use triplicate prescription forms for ordering controlled substances, and prescribed in a manner that threatened the health and safety of patient JJ. On May 18, 2009, the Board issued an Amended Notice of Proposed Disciplinary Action alleging that while the Licensee's dental license was suspended, ordered 24 Vicodin, 30 Tramadol, and 60 Penicillin for a relative/patient GB without using triplicate prescription forms; while the Licensee's Oregon dental license was suspended, ordered 20 Vicodin, and two Ativan for a relative/patient GB, without using triplicate prescription forms; while the Licensee's Oregon dental license was suspended, ordered 24 Oxycodone and 30 penicillin for a relative BD, with no dental justification and without using triplicates prescription forms; and while the Licensee's license was suspended, ordered prescription drugs for GB and BD. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into an Amended Consent Order with the Board in which the Licensee agreed to resign the Licensee's dental license in lieu of the Board pursuing further disciplinary action.

Case #2007-0069 On September 14, 2007, by an Amended Consent Order, the dentist agreed to be placed on indefinite probation with conditions that included adhering to, participating in, and completing all recommended continuing care programs; advising the Board of any changes or alteration to any continuing care programs 14 days before the changes went into effect; advising the Board within 72 hours of any substantial failure to participate in any recommended recovery program; personally appearing before the Board

three times a year; participating in an anger management counseling regimen for a minimum of one year; and participating in a counseling regimen for a period of five years. Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to comply with the conditions of probation. The Licensee failed to request a hearing in a timely manner so the Board issued a Default Order in which the Licensee's license to practice dentistry was revoked.

Case #2008-0220 Based on the results of an investigation, the Board issued an Amended Notice of Proposed License Suspension, alleging Licensee drank alcohol as evidenced by Licensee's urine samples, collected on November 13, 2008 and December 31, 2008, that tested positive for ethyl glucuronide which is a direct metabolite of ethanol; on or about December 30, 2008, Licensee failed to provide a urine sample for testing upon request from a counselor at a scheduled Recovery Support Program group meeting; on or about January 5, 2009, Licensee advised Serenity Lane he was discontinuing participation in the Recovery Support Program and directed Serenity Lane to not test the urine sample collected on December 31, 2008; on January 6, 2009, Licensee failed to attend a regularly scheduled Recovery Support Program meeting; Licensee failed to advise the Board of the Licensee's failure to provide a urine sample for testing and failure to attend a Recovery Support Program meeting within 72 hours of those events; between December 29, 2008 and January 9, 2009, Licensee failed to respond to a written request for information from the Board; and on January 9, 2009, Licensee provided false written information to the Board regarding his recovery treatment. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to resign the Licensee's license to practice dentistry in lieu of the Board pursuing further disciplinary action.

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DISCIPLINARY ACTIONS (Continued from page 11)**Prohibited Practices (Making False Written or Oral Statements) ORS 679.170(5)**

Case #2009-0007 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist 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 certifying that between April 1, 2006 through March 31, 2008 the Licensee was not involved in any pending or final disciplinary action, when, in fact, on September 24, 2007, the Medical Board of California filed a First Amended Accusation against the Licensee in case 05-2004-158014; and on June 6, 2008, the Licensee was disciplined in the Stipulated Settlement and Disciplinary Order in case 05-2004-161299 that was adopted as the Decision and Order of the Medical Board of California and became effective on that date. The Licensee failed to request a hearing in a timely manner so the Board issued a Default Order in which the Licensee was reprimanded, placed on probation for a period of two years effective June 6, 2008, and subject to the terms of the Medical Board of California Stipulated Settlement and Disciplinary Order in case 05-2004-161299, and to pay a civil penalty of \$5,000.00.

Case #2008-0208 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist instructed Licensee's office manager to sign Licensee's name to Licensee's 2008-2010 license renewal application, in an attempt to mislead the Board, as there was no accompanying explanation as to the failure of Licensee to personally sign the renewal form; and that during the investigation statements given were inconsistent with actual dates on documents. Aware of the Licensee's right to a hearing, and in order to resolve this matter,

the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded.

Case #2008-0218 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that on March 27, 2008, a dentist made an untrue statement on the Licensee's License and Permit Renewal Application form to practice dentistry in Oregon when the Licensee answered "Yes" to question number 10B, that the Licensee had completed, or would complete 4 hours of continuing education, by March 31, 2008, required to maintain the Licensee's Class 1 (Nitrous Oxide) Permit; when, in fact, that continuing education was not completed. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded and to provide eight hours of Board approved pro bono Community Service which shall involve the Licensee providing direct dental care to patients.

Case #2009-0101 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist Licensee engaged in the practice of dental hygiene after failing to renew the Licensee's license to practice dental hygiene on or before September 30, 2008; attempted to deceive the Oregon Board of Dentistry by presenting a false written statement to the Board that was allegedly written and signed by the Licensee's employer informing the Board that the Licensee had not performed duties of a hygienist between October 1, 2008 and October 6, 2008; and during an interview with an investigator of the Oregon Board of Dentistry, the Licensee attempted to deceive the Board with regard to a matter under investigation. Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded, to pay a \$500.00 civil penalty, and to provide community service consisting of 80 hours of Board approved, pro bono, direct patient care. ■

NEW DUTY TO REPORT LAW

A new Duty to Report law passed the 2009 Legislature requiring licensees to report “prohibited or unprofessional conduct” of other health licensees to their professional licensing boards without undue delay, but within 10 days. These new Duty to Report provisions join the existing OBD Duty to Report requirements of ORS 679.310.

Under these provisions, a Dentist or a Dental Hygienist who has reasonable cause to believe a medical doctor, licensed massage therapist or a physical therapist (for example) were violating that profession’s laws or rules, would be required to make a report directly to the OBD.

The new law requires reporting of “prohibited conduct” a conduct by a licensee that:

(A) Constitutes a criminal act against a patient or client; or (B) Constitutes a criminal act that creates a risk of harm to a patient or client; and the new law requires reporting of “Unprofessional conduct” which means conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to recognized standards of ethics of the licensee’s profession or conduct that endangers the health, safety or welfare of a patient or client. In the rare situation where the other health professional is the Dentist’s or Dental Hygienist’s patient, the HIPAA implications should be considered before any reporting.

The new law also requires that a Dentist or Dental Hygienist must report to the OBD within 10 days any arrest for, or conviction of, a felony offense. A Dentist or Dental Hygienist

who is convicted of a misdemeanor or a felony offense must report this to the OBD within 10 days. It is a Class A violation if you fail to report. Please note the report is confidential by this law and the reporter who reports in good faith is immune from civil liability for making the report. The OBD will continue to ask on all renewal forms whether any criminal convictions or arrests have occurred. Any failure to promptly report could result in disciplinary action.

There is no prescribed format for reporting. A telephone call, fax, email or letter are all effective methods to communicate with the intended health regulatory board. What is important is that the information be sufficiently detailed and well founded for the agency’s review and response. ■



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The Board office is open from 7:00 a.m. to 4:00 p.m., Monday through Friday, except State and Federal holidays.
 Phone: 971-673-3200 Fax: 971-673-3202

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

SCHEDULED BOARD MEETINGS

2010

- January 22, 2010
- March 19, 2010
- May 21, 2010
- July 23, 2010
- October 1, 2010
- December 17, 2010

NEW BOARD MEMBER

Brandon J. Schwindt, D.M.D., of Portland, joined the Board in November 2009 following his appointment by Governor Kulongoski and confirmation by the Oregon State Senate to the specialist seat on the OBD. Dr. Schwindt has a B.S. degree in Biology from the University of Oregon and received his D.M.D. degree from OHSU.



He has been practicing dentistry for six years in Oregon and is a member of the American Dental Association, Oregon Academy of Pediatric Dentistry where he has served as President, Oregon Dental Association and the Multnomah and Washington County Dental Societies. Dr. Schwindt is Fellow of the American Academy of Pediatric Dentistry and a Diplomate of the American Board of Pediatric Dentistry.

Dr. Schwindt is married to Katherine Bowman, D.M.D., who practices dentistry in Woodburn, Oregon. ■

FAREWELL TO BOARD MEMBER

We wish to extend a great big “Thank you” to Dr. Melissa Grant of Lake Oswego for her eight plus years of dedicated service to the Board of Dentistry and the citizens of Oregon. Dr. Grant served in many different roles including President of the Board, Newsletter Editor and Chair of the Communication Committee. Dr. Grant occupied the specialist seat on the OBD.

At the request of the Governor, Dr. Grant served beyond the expiration date of her term as the Governor was working to appoint her successor.

Dr. Grant and her great sense of humor will be missed by her fellow Board members and the OBD staff and we wish her well in her future endeavors. ■

IMPORTANT INFORMATION

Effective November 1, 2009 the Oregon Board of Dentistry (OBD) will no longer automatically mail Notices of Proposed Rulemaking. In the past, mailings have gone out to over 7,000 licensees each time there is a proposed rule change, at a cost of over \$6,000 for each mailing. Over 5% of the mail is returned to the Board with bad addresses. To help control the rising cost of these mailings, the OBD is asking that Licensees tell us if they want to receive these notices and how they would like to receive them, via email (the preferred method) or mailed to them. If you don't reply, you will no longer receive notification; however, rulemaking information will always be available on the Board's Web site.

Please complete the following information if you would like to continue to receive the OBD's Notices of Proposed Rulemaking. Please submit this information to the OBD via the OBD's Web site (www.oregon.gov/dentistry) under Electronic Notice Request, fax (971-673-3202) or mail (Oregon Board of Dentistry, 1600 SW 4th Avenue, Suite 770, Portland, Oregon 97201). **Please print legibly.**

Name: _____ License No. _____

Please send future Notices of Proposed Rulemaking to the following:
(Check Appropriate Box)

Mailing Address: _____

Email Address: _____

OREGON BOARD OF DENTISTRY

1600 SW 4th Avenue, Suite 770

Portland, OR 97201-5519

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.



Licensees are required to report any change of address within 30 days.

CHANGE OF ADDRESS FORM

Licensee Name: _____
Print Name *Phone*

License Number: _____

New Mailing Address: _____

Above is: Home Office Other

Mail or Fax to: **OREGON BOARD OF DENTISTRY**

1600 SW 4th Avenue, Suite 770

Portland, OR 97201-5519

Phone: (971) 673-3200

Fax: (971) 673-3202