Maine Board of Dental Practice
Board Meeting Minutes
February 10, 2017

The meeting convened at: 8:30 a.m.

Members Present: Drs. Geraldine Schneider; Lisa Howard; Stephen Morse; and Glen Davis; Ms. Nancy Foster, RDH, EFDA; Ms. Catherine Kasprak, RDH; Ms. Rowan Morse, Public Member; and Ms. Kathryn Young, LD

Member Absent: Dr. Paul Dunbar

Also Present: Ann Marie Grenier, RDH; David Wicks, DDS; Bonnie Vaughan, RDH; David Pier, DMD; Daniel Steinke, DDS; Howard Bates, DMD; James Belleau, Esquire; Jon Chrisos; Lauren LaRochelle, AAG; James Bowie, AAG; Andrew Black, AAG; Teneale Johnson, Executive Secretary; and Penny Vaillancourt, Executive Director

Addition to Agenda: The Board voted to go into executive session pursuant to 1 M.R.S. §405 at 8:35 a.m. to discuss a personnel matter. The Board came out of executive session at 9:16 a.m. Dr. Howard made a motion to send a letter to the Attorney General, requesting that reassignment of legal counsel be made [redacted]. Dr. Morse seconded the motion and it passed unanimously.

Subcommittee on Dental Hygienists Report: Ms. Grenier reported the following from the Subcommittee on Dental Hygienists meeting:

- Application for Dental Hygiene License Renewal – Marilyn Clark, RDH: Ms. Clark did not file a timely request for an extension to obtain her CPR re-certification as it was not current at the time of license renewal. The Subcommittee recommendation was to renew Ms. Clark's license and send a letter informing her of the renewal process. Dr. Davis made a motion to accept the Subcommittee recommendation. Dr. Morse seconded the motion and it passed with Ms. Foster opposed.

- IPDH Authority Application – Patricia Ericson, RDH: The Subcommittee reviewed an application for Independent Practice Dental Hygiene Authority for Ms. Ericson and recommends that the Board approve her application. Ms. Kasprak made a motion to accept the Subcommittee recommendation. Dr. Morse seconded the motion and it passed unanimously.

- Consent Agreement Compliance Documentation – Julie Valente, RDH: Ms. Valente provided documentation showing proof of continuing education credits in compliance with a consent agreement dated October 30, 2016. The Subcommittee recommends that the Board accept the documentation provided. Dr. Morse made a motion to accept the recommendation. Dr. Davis seconded the motion and it passed unanimously.

Subcommittee on Dental Hygienists Report (Cont'd):

- The Subcommittee also made a recommendation that IPDH Authority applications be reviewed by Board staff unless there is something that needs Subcommittee/Board attention. Dr. Davis made a motion to accept the recommendation. Ms. Kasprak seconded the motion and it passed unanimously.

Review of Interim Consent Agreement Re: Dr. David Steuer: Based on non-compliance with a consent agreement dated November 18, 2016, the Board voted to immediately suspend Dr. Steuer's license on January 20, 2017. Dr. Steuer has agreed to enter into an interim agreement whereby it would extend the license suspension until March 11, 2017 in order to possibly reach an agreement to resolve the issue of non-compliance with the November consent agreement. The Board agreed to the terms outlined in the interim consent agreement.

Review of Draft Consent Agreement RE: Complaint Nos. 15-37, 16-46, and 16-70: Due to non-compliance with the original consent agreement dated November 18, 2016, Ms. Foster made a motion to amend the language of the consent agreement to read that the license would continue to be suspended until such time as a practice monitor has been approved by the Board. Ms. Kasprak seconded the motion for purposes of discussion. The motion was amended to correct a grammatical error in the draft, and that the licensee is required to submit three candidates for practice monitor, and that the civil penalty imposed be $3,000 as opposed to $1,000. The motion passed with Dr. Howard and Ms. Young opposed due to the increased civil penalty.

Decision and Order – Donna M. Vix, DMD: Following review of the draft agreement, Dr. Davis made a motion to accept the draft as amended. Dr. Howard seconded the motion and it passed with Dr. Morse recused.

Minutes – December 9, 2016: Dr. Morse made a motion to accept the December minutes as drafted. Dr. Davis seconded the motion and it passed unanimously.

Executive Director's Report:

- Legislative Update: Ms. Vaillancourt provided an update to the Board regarding LD 13 "An Act To Require Certain Licensing Boards To Report Cases of Sexual Abuse of a Patient or Client by a Licensee to a Law Enforcement Agency or the Department of Health and Human Services" which was voted "ought not to pass" by the Legislative Committee.

- Rulemaking Update: The Board will be holding a rulemaking hearing later in the day on proposed rule, chapter 14; and will also be reviewing draft board rule, chapter 13.

- Adjudicatory Hearing Update: The Board will be conducting adjudicatory hearings in the coming months.

<u>Executive Director's Report</u> (Cont'd):

- Complaint Committee Update: Ms. Vaillancourt reported that the complaint committee continues to triage complaints as they come into the Board.

- Investigator/Inspector Interviews: There are five candidates who met the initial qualifications for the open position and will be interviewed by Ms. Vaillancourt and Commissioner Anne Head.

- Statute Review Update: Ms. Vaillancourt will provide an overview of the changes to the Board's statute at future meeting.

- Financial Report Update: Ms. Vaillancourt will request someone from the Commissioner's office come to a future meeting to provide an overview of the State Budget processes.

<u>Criminal Background Check Report</u> – Nicole Horton, DDS: When an individual applies for and obtains a license with the Board, the application process includes criminal background checks from any state the applicant resided in the previous ten years. In most cases, licensure is not held up while awaiting the background check(s) due to the length of time this takes. Dr. Horton applied for and obtained a dental license July 2016. Her criminal background check was recently received which showed a positive result. Following the Board's review of the information, along with an explanation of the events from Dr. Horton, Ms. Foster made a motion to send her a letter thanking her for the explanation and reminding her of the 10-day reporting requirement. Dr. Morse seconded the motion and it passed unanimously.

<u>Dental Radiography License Renewal</u> – Sarah Burton: At its meeting in October 2016, the Board voted to table Ms. Burton's renewal application and reconsider the application at its February 10th meeting based on information related to a deferred disposition hearing scheduled for January 2017 regarding criminal charges. Ms. Burton provided documentation showing that she was convicted of criminal trespass and disorderly conduct which included jail time. Dr. Davis made a motion to renew Ms. Burton's dental radiography license and send her a letter reminding her of the 10-day notification requirement. Dr. Morse seconded the motion and it passed unanimously.

<u>Dental Radiography License Application</u> – Amanda Waldron: Ms. Waldron has applied for a dental radiography license based on successful completion of a Board approved examination in radiation health and safety. Ms. Waldron also provided documentation showing that following completion of the examination, she obtained a dental assistant license in Massachusetts, which the scope includes, taking radiographs.

Dental Radiography License Application – Amanda Waldron (Cont'd):

1. Will the board accept the fact that this individual did obtain a dental assistant license in Massachusetts which allows the individual to take radiographs? Ms. Kasprak made a motion to accept the documentation provided by the Dental Assisting National Board (DANB), and proof of her licensure in Massachusetts as qualifying her for a Maine dental radiography license. Dr. Davis seconded the motion and it passed unanimously.

2. In addition, DANB is now offering a verification of individual's certification which Board staff is requesting confirmation of whether it is acceptable to the Board. Ms. Kasprak made a motion to accept the certification verification offered by DANB as proof of successful completion of a radiation health and safety examination. Ms. Young seconded the motion and it passed unanimously.

Dental Radiography License Application – Heather Melcher: Following review of the application materials, Dr. Morse made a motion to grant Ms. Melcher a dental radiography license. Ms. Kasprak seconded the motion and it passed unanimously.

Dental Extern Registration – Alex Kerbaugh: Mr. Kerbaugh filed a dental extern registration and responded affirmatively to question #1. Following their review of the explanation of events, and documentation, Dr. Howard made a motion to grant Mr. Kerbaugh the extern registration and send him a letter reminding him of the 10 day notification requirement, and information for the Maine Medical Professionals Health Program. Dr. Morse seconded the motion and it passed unanimously.

Application for Dental Licensure – Victor Hwang, DMD: Dr. Hwang filed a dental license application and responded affirmatively to one of the questions. Ms. Young made a motion to enter executive session pursuant to 1 M.R.S. §405 at 11:11 a.m. to discuss confidential medical information. Dr. Davis seconded the motion and it passed unanimously. Once out of executive session, Dr. Morse made a motion to grant a dental license to Dr. Hwang. Dr. Howard seconded the motion and it passed unanimously.

Complaint 16-100 – Compliance Reporting Documentation: Following review the documentation showing the practice closure requirements as agreed to in a consent agreement dated December 13, 2016, the Board voted to accept the documentation. The motion passed with Ms. Foster abstained as she was out of the room.

Draft Proposed Rule – Chapter 13 – "Continuing Education": Following review of the draft rule, and additional changes, Dr. Howard made a motion to accept the draft rule as amended. Ms. Young seconded the motion and it passed unanimously. Dr. Howard made a motion to approve chapter 13 with the above amendments as the board's proposed rule. Dr. Morse seconded the motion and it passed unanimously.

Ad Hoc Committee – Phase II Statutory Review: Ms. Vaillancourt provided an update on the Ad Hoc Committee meetings held to date.

Medical Malpractice Report – Dated 12/16/16: Following review of the information, Dr. Davis made a motion to generate a Board complaint to further investigate this matter for potential violations of standard of care, including what were the protocols in place, and what follow up medical services were provided to the patient. Dr. Morse seconded the motion and it passed unanimously.

Medical Malpractice Report – Dated 1/9/2017: Following review of the report, Dr. Morse made a motion to generate a Board complaint in order to further investigate the matter. Dr. Davis seconded the motion and it passed unanimously.

Rule Making Hearing – Board Rule, Chapter 14 –
"Rules for Use of Sedation and General Anesthesia"

This public hearing is for purposes of accepting comments to the Board's proposed rule, Chapter 14. The deadline for comments to be submitted on this proposed rule is set for March 13, 2017. The following comments were made during the hearing:

Dr. Daniel Steinke – Maine Academy of General Dentistry (Dover Foxcroft and Sorrento)

- Requiring CO^2 capnography – Dr. Steinke states that there has not been any situation of a serious consequence that would warrant that this unit be a requirement for offices who provide moderate sedation; but if put in place, it should be graded into the next three years, as a new unit would need to be purchased.

- ECG Monitoring – Dr. Steinke stated that the wording is ambiguous with regards to use of ECG monitoring, and it would be a legal nightmare, and stated that according to Dr. Stanley Malamed, it is more safe to use sedation than nothing at all. Dr. Steinke does not feel ECG monitoring is necessary for the administration moderate oral sedation.

- Administration of Medications – the wording implies that the dentist must be present when all drugs are administered to patients. Dr. Steinke's suggests that the Board amend the wording of this section of the rule as some medications are provided to the patient to take prior to their arrival at the dental office.

Dr. David Pier – representing himself

- Access to Care – Dr. Pier urges that Board to take into consideration the access to care for patients when amending the rule.

Rule Making Hearing – Board Rule, Chapter 14 (Cont'd):

- ACLS Algorithm Card – Dr. Pier believes that the ACLS algorithm card requirement should be removed from the minimal sedation section, as these individuals are not required to obtain ACLS certification, therefore, having the card does not make sense.

- Pulse Oximeter – Dr. Pier believes that the Board should remove the requirement of continuous use of the pulse oximeter as this adds to the process which may deter dentists from providing minimal sedation and therefore impacting access to dental care.

- ECG Monitoring – The proposed rule states that ECG monitoring should be used for anyone having significant cardiac disease. Dr. Pier suggests amending the language to state that anyone with an ASA III classification or higher.

- CO^2 Capnography – Dr. Pier suggested that the CO^2 capnography requirement be removed as there is no benefit, and it is harmful to the environment.

- 14-day reporting reference – Dr. Pier stated that he did not understand the 14-day reporting notification and suggests that the wording may need to be amended.

- Administration of Medications – Dr. Pier noted the same concerns as Dr. Steinke, stating that some medications are provided to the patient to take prior to arriving at the dental office and that the language should be revised to accommodate those instances.

The rulemaking hearing closed at 1:20 p.m. The Board will review all written and verbal comments at a future meeting.

Medical Malpractice Report – Dated 1/13/17: Following review of the Report, Ms. Foster made a motion to generate a board complaint in order to further investigate the matter. Dr. Davis seconded the motion and it passed unanimously.

Review of Letter from James E. Smith, Esquire RE: Advertising: Attorney James Smith was requesting whether the Board was aware of any rule or law that regulates specialties. The Board voted to respond stating that the Board is not aware of any other rule or law, and thanking him for bringing the information to the Board's attention. The Board will add this **Review of Letter from James E. Smith, Esquire RE: Advertising (Cont'd):** letter to the list of issues to discuss with the Ad Hoc Committee who is reviewing the Board's statute.

Initial Complaint Presentations:

Complaint 16-43: The complainant alleged that they woke up during a procedure while under general anesthesia, that they had excessive bleeding, and an infection that followed. Possible violations for this case would be failure to document in the patient record, failure to properly discharge, failure to obtain informed consent, failure to assess pain, failure to continuously monitor patient during IV sedation administration, and failure to provide follow up consultation with referring dentist.

Complaint 16-38: The complainant alleged that they were denied general anesthesia upon request; the tooth was pulled without being put under, and the wrong tooth was pulled. The patient filed a rebuttal to the licensee's response stating that there were untrue statements in the licensee's response, the licensee was aggressive, and that the patient tried to stop the procedure. The licensee recalls no complications. The patient appears to have had an appointment prior to the procedure in question which is when a PA was taken. Possible violations for this case include failure to obtain informed consent; failure to assess patient's pain; lack of radiograph on file; failure to document intraoperative incidents and/or complications, and failure to appropriately communicate with referring dentist pre operatively and post operatively.

Complaint 16-40: The complainant alleged that the licensee left roots behind, their face was still swollen following surgery, they were refused additional medication post-operatively, they were crying during the procedure, and there was a bubble over the extraction site and numbness in the tongue following the surgery. Possible violations for this case would be, failure to obtain informed consent on three separate occasions; failure to assess and reassess patient's pain; failure to document pre operatively, intra operatively, and post operatively in the record; and lack of communication with referring provider.

Complaint 16-42: The complainant alleged that they were denied general anesthesia due to prior drug use, they asked the licensee to stop during the procedure due to pain, and following the procedure they were sobbing and pulled into dark room where their escort was waiting. Possible violations for this case would be failure to document in the record, failure to appropriately assess the patient, failure to obtain informed consent, failure to continuously monitor patient during the administration of IV sedation, aiding and abetting the practice of dentistry, and improper delegation of a procedure.

Complaint 16-45: The patient alleged that they went in for extraction of five teeth. During the procedure, they were screaming and crying, there was more teeth pulled than what they had consented to, they had uncontrolled bleeding following the procedure, they were not properly discharged, and they cannot wear the partial denture that was made for them. Possible violations for this case would be failure to obtain informed consent, unnecessary exposure to ionizing radiation, failure to properly assess patient, failure to document in the record, and discharging the patient without a proper post-operative assessment.

Initial Complaint Presentations (Cont'd):

Complaint 16-37: The complainant alleged that they were denied general anesthesia for the procedure and they were in pain during the surgery. The licensee would not stop when asked by the complainant and they were escorted to the side back door when discharged. Possible violations for this case include failure to obtain informed consent, failure to assess the patient; failure to continuously monitor patient during administration of IV sedation, failure to properly discharge the patient, inadequate documentation; and inadequate images.

Complaint 16-47: The complainant alleged that they were denied general anesthesia for their surgery and they were grasping the dental chair in pain during the procedure. The complainant called following extraction to request a copy of their records including the type of anesthesia provided. Possible violations for this case include failure to obtain informed consent, failure to assess the patient's pain, failure to diagnose, failure to document in the patient record, failure to continuously monitor patient during administration of IV sedation, failure to provide follow up consultation with the patient's dentist, and discharging the patient without proper medical evaluation.

Complaint 16-69: The complainant alleged that they felt pain during the procedure, and that the assistant held the patient's shoulder down and wiped their tears away. The complainant also alleged that they were told to swallow their blood. Possible violations for this case include failure to obtain informed consent, failure to properly assess patient, failure to continuously monitor patient during administration of IV sedation, failure to document appropriately in the patient record, failure to appropriately discharge the patient, and failure to refer the patient for further treatment.

Complaint 16-5: The complainant alleged that the appointment was supposed to be for a consult only, but procedures were performed. Possible violations for this case include failure to obtain informed consent, failure to properly assess patient in pain, failure to document appropriately in the patient record, and failure to refer the patient for further evaluation and treatment.

Complaint 16-21: The complainant alleged that they were refused pain medication upon request, and the local anesthesia did not take effect prior to beginning the treatment. It was also alleged that the licensee chipped two other teeth during the procedure; left bone exposed, and used no gloves during procedure. Possible violations for this case include failure to assess pain during procedure, failure to document appropriately in the patient record, failure to follow appropriate infection control procedures, failure to properly discharge patient, and failure to provide follow up consultation with referring dentist and primary care provider.

Initial Complaint Presentations (Cont'd):

Complaint 16-6: The complainant, who was a former employee and worked only 1-2 days, alleged that the autoclaves were not properly working and dawn dish soap was being used to clean the instruments. There was no formal training, and they were concerned that assistants were performing procedures outside their scope of practice. Possible violations include failure to use appropriate infection control procedures; failure to follow current OSHA and CDC guidelines, and failure to maintain appropriate documentation.

Complaint 16-71: The complainant alleged a billing issue, and stated that claims had not been submitted for services provided. Potential violations for this case include, failure to properly assess patient, failure to maintain appropriate documentation in the patient record, failure to continuously monitor patient during the administration of IV sedation, failure to properly discharge patient, failure to provide follow up correspondence with referring dentist, and improper delegation of duties to dental assistants.

Complaint 16-11: The complainant alleged that they woke up during the procedure crying and asking the licensee to stop, they were held down, and they were not provided any pain medication post operatively. Possible violations for this case include failure to properly assess patient, failure to document appropriately in the patient record, failure to continuously monitor patient during administration of IV sedation, failure to properly discharge patient, improper delegation of duties to dental assistant, and failure to provide follow up consultation with referring dentist.

Complaint 16-19: The complainant alleged that the wrong teeth were pulled, that they woke up choking on their own blood, and that the wrong postoperative prescription was provided and resulted in subsequent visits to the emergency department and primary care provider. Possible violations for this case include failure to obtain informed consent, failure to properly assess patient, failure to document appropriately in the patient record, failure to continuously monitor patient during administration of IV sedation, and failure to properly discharge patient post operatively.

Complaint 16-20: The complainant alleged that the licensee did not use appropriate numbing agents prior to performing procedure, they were crying, and the patient's lip was cut which they believe was done on purpose. The complainant also stated that while in the waiting room, screams could be heard from other patients being treated. Possible violations for this case include failure to obtain informed consent, failure to assess the patient appropriately, and failure to document appropriately in the patient record.

Initial Complaint Presentations (Cont'd):

Complaint 16-22: The complainant alleged that they were not properly sedated and the wrong tooth was pulled. When they went to a subsequent emergency department visit, they were told to find another oral surgeon. Possible violations for this case include, failure to obtain informed consent, failure to properly assess patient, failure to document appropriately in the patient record, failure to provide post-operative medications for pain and infection, and failure to communicate sufficiently with referring dentist regarding patient's condition and appropriate treatment

Complaint 16-39: The complainant alleged that the local anesthesia injection was painful, they were crying during the procedure, the licensee was cranking on the tooth and part of it went flying and the licensee did not change gloves when returning to room. The complainant also said that the assistant said they should have been put to sleep for the procedure while escorting them out the back door. Possible violations for the case include failure to properly assess the patient, failure to properly document in the patient record, failure to provide appropriate aftercare instructions to the patient, failure to communicate sufficiently with referring dentist regarding patient's condition and appropriate treatment, and failure to wear clean gloves during dental extraction.

Complaint 16-103: The complainant alleged that the licensee removed twenty teeth without appropriate anesthesia and removed too much bone. The complainant alleged that they were screaming in pain during the procedure and they also question the billing for the procedure. Possible violations for this case include failure to obtain informed consent regarding alveoplasty, failure to properly assess the patient, failure to communicate sufficiently with the referring provider regarding the patient's condition and appropriate treatment, failure to document in the patient's record, failure to protect patient safety in the use of general and local anesthesia, failure to continuously monitor patient during administration of IV sedation, and failure to properly discharge patient.

An inspection of the licensee's practice was conducted in March 2016 which also raised potential violations including improper infection control procedures, expired mediations mixed in with current medications, the posted radiograph equipment registration(s) was expired, the licensee's office manual was out of date, and compliance with OSHA and CDC guidelines. In addition, the licensee entered into a consent agreement with the Board and the Office of the Attorney General whereby the licensee agreed to comply with the AAMOS guidelines.

Dr. Morse made a motion to issue an immediate suspension of the license and set the matters for an adjudicatory hearing. Dr. Schneider seconded the motion and it passed with Ms. Foster recused as the Complaint Officer.

Initial Complaint Presentations (Cont'd):

Dr. Davis made a motion stating that the notice of hearing should list the potential violations as outlined by the Complaint Officer during the complaint presentation. Ms. Young seconded the motion and it passed with Ms. Foster recused as the Complaint Officer.

Dr. Davis made a motion to delegate the review/approval of the immediate suspension order to the Board Chair. Dr. Morse seconded the motion and it passed with Ms. Foster recused as the Complaint Officer.

Complaint 17-01: Dr. Davis made a motion to table the complaint. Dr. Morse seconded the motion and it passed with Ms. Foster recused as the Complaint Officer.

Addition to Agenda: Ms. Young made a motion to enter executive session pursuant to 1 M.R.S. § 4056 (F) for purposes of consulting with legal counsel. Dr. Davis seconded the motion and it passed unanimously. The Board came out of executive session at 7:35 p.m. While in executive session, Legal Counsel discussed procedural issues, and use of public information laws and going into executive session; as a general rule the Board should always have legal counsel present.

Review of Draft Joint rule – Chapter 21 "Use of Controlled Substances for Treatment of Pain": The Board agreed to not adopt the proposed rule as drafted by the Board of Licensure in Medicine and the Board of Osteopathic Licensure.

American Association of Dental Boards – Mid Year Meeting: The Board agreed that it would not send a Board representative to this meeting.

The following agenda items were accepted as FYI's:

E-mail from Dr. Thomas Million RE: Change of Address
Letter from Dr. Leonard Brennan RE: Sale of Practice
Continuing Education Approval List
Preliminary Agenda for Upcoming Meetings
Old Business – Maine Medical Professionals Health Program Draft Protocols
Case Management Report

Addition to Agenda: The Board agreed to send a letter to the Maine Attorney General requesting a reassignment of legal counsel [redacted]

The meeting adjourned at 7:48 p.m.

Respectfully Submitted,

Teneale E. Johnson
Executive Secretary