



### PRESIDENT'S MESSAGE

by *Jonna Hongo, D.M.D.*  
2013-2014



**S**terilization of instruments — a basic procedure in every dental office. However, OAR 818-012-0040(4) of the Dental Practice Act states: “Heat sterilizing devices shall be tested for proper function on a *weekly* basis by means

of a biological monitoring system that indicates micro-organisms kill.” This rule was implemented in 2004 and follows the current infection control guidelines of the Centers for Disease Control and Prevention. The high profile case of the Oklahoma oral and maxillofacial surgeon who failed to follow basic infection control protocols has heightened public focus on dentistry — not just in Oklahoma, but nationwide. With the mission of protecting the public in mind, the Oregon Board of Dentistry has responded to this crisis by requesting the documentation of proper and timely testing results of sterilizers in the course of our investigations. Surprisingly, and sadly, a significant number of cases have uncovered the lack of adherence to this rule. “Reasons” given for this failure range from, “Didn’t it used to be once a month?” to “When did it change?” to “My assistant is supposed to take care of that.”

Licensees, please be sure you are providing sterile instruments to your patients. Delegating

responsibility is necessary in our busy practices, but the ultimate accountability lies with you, the licensee. There are numerous testing modalities available to today’s practitioner. The important thing to remember is that the results are documented, compiled and retained in your records. Right here in our own backyard at the OHSU School of Dentistry we have one of the finest sterilizer monitoring services available. If you are looking for a reasonable service, user-friendly system and instant record-keeping structure, I direct you to the OHSU home page and search for “sterilizer monitoring.” It’s as simple as that to comply. ■

*Below is the link to the CDC Guidelines for Infection Control in Dental Health-Care Settings (2003)*

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm>

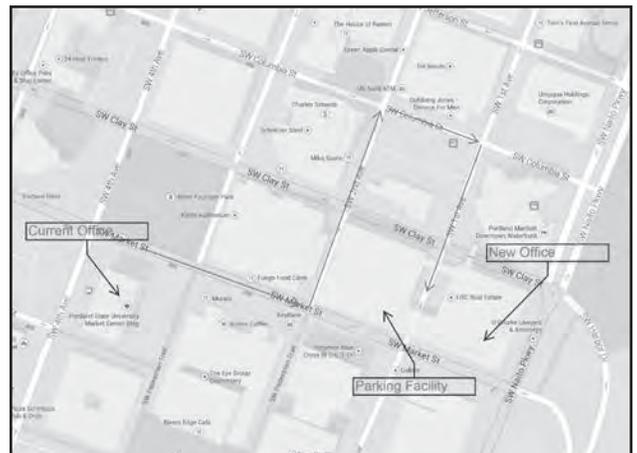
### We’ve moved! (Dec. 9, 2013)

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Portland, OR 97201**

(971) 673-3200 Phone

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[www.oregon.gov/Dentistry](http://www.oregon.gov/Dentistry)



The OBD move to the Crown Plaza will occur in early December 2013.

**Mail all payments to the same PO Box:**

Unit 23, PO Box 4395

Portland, OR 97208-4395

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# 10

by Patrick D. Braatz, Executive Director



**A**ugust 4, 2003 to August 4, 2013 are the dates that mark ten years that I have been the Executive Director of the Oregon Board of Dentistry. One decade, 120 months, 520 weeks, 3,650 days, 87,600 hours, and 5,256,000 minutes.

During that period of time, I have overseen the issuance of 1,783 new dental and 2,070 dental hygiene licenses, the opening of 2,529 cases and the closing of 2,373 of those cases. Three hundred twenty five disciplinary orders were issued, 712 Letters of Concern were written, and 781 cases were closed for No Violation and 615 for No Further Action. Staffed 62 regular Board of Dentistry board meetings.

The Board has had two offices during this time and is about to move to a third location. Two staff left the OBD and two new staff replaced them.

Five Biennial OBD Budgets were adopted by the Oregon Legislature; and I have testified many times before the Oregon Legislature as well as worked with two different Governors. I have had the opportunity to serve as President of the American Association of Dental Administrators and as the Administrative Member of the Executive Council of the American Association of Dental Boards. I have served 20 different board members of the Oregon Board of Dentistry.

Adopted and modified almost 100 Administrative Rules during the last ten years.

I have made well over 150 presentations to Oregon Licensees through the DBIC Risk Management Programs, made presentations to the Oregon Dental Association, Oregon Dental Hygienists' Association, and the Oregon Dental Assistants Association.

Frankly, some days it is very hard for me to believe that ten years have gone by that fast and then some days it feels like it has been a lifetime!!!!

The OBD has tackled many difficult and controversial issues during the last ten years and I have, as a non-dental person, tried to guide the Board in always looking out at their primary mission, "The Protection of

the Public." The most recent controversial issue really is appearing to be a very big problem.

In 2004, the OBD made a change to OAR 818-012-0040 Infection Control Guidelines when it changed from requiring monthly testing to weekly testing of heat sterilizing devices by means of a biological monitoring system that indicates micro-organisms kill.

Following that Administrative Rule Change, every licensee was notified of that change and every OBD Practice Act printed since that time and placed on our website has listed that new requirement.

Yet today, the OBD is finding licensee after licensee have not been following what some might call "Basic Dentistry 101."

The Board has made it clear that in carrying out its primary mission of "Protection of the Public," that those individuals that have not complied with this very basic requirement of safe practice are subject to disciplinary action. Some of the cases that the Board has investigated and reviewed have found that some licensees in a 12 to 24 month period have done no "spore testing" or almost no "spore testing" and this is not good and the public truly demands better from the profession.

The Board does not make the decision to issue discipline without great discussion, debate and consternation. The OBD staff and I do not have a vote on the Board, nor do we get to make the decision to seek disciplinary actions or what those actions will be.

I urge all licensees to review the current Dental Practice Act that can be found at <http://www.oregon.gov/dentistry/Pages/regulations.aspx> and suggest that you make sure that you are aware of all the laws, rules and requirements that Oregon Board of Dentistry Licensees are subject to.

As always, please feel free to contact me with your questions, concerns or comments at (971) 673-3200 or by email at [Patrick.Braatz@state.or.us](mailto:Patrick.Braatz@state.or.us) or by stopping by our new OBD Office in the Crown Plaza Building located at 1500 SW 1<sup>st</sup> Avenue, Suite 770, in downtown Portland. ■

## SCHEDULED BOARD MEETINGS

2014

- February 28, 2014
- April 25, 2014
- June 27, 2014
- August 22, 2014
- October 17, 2014
- December 19, 2014

## FAREWELL TO BOARD MEMBER

We wish to extend a great big “Thank you” to Jill Mason, R.D.H., of Portland for her eight plus years of dedicated service to the Board of Dentistry and the citizens of Oregon. Ms. Mason served in many different roles including President of the Board, Chair of the Dental Hygiene Committee, and member of the Rules Oversight and the Enforcement & Discipline Committees. Ms. Mason occupied one of the dental hygiene seats on the OBD.

Ms. Mason and her great sense of humor and punctuation skills will be missed by her fellow Board members and the OBD staff. We wish her well in her future endeavors. ■

## NEW BOARD MEMBERS

Todd Beck, D.M.D., of Portland joined the Board in April 2013 following his appointment by Governor Kitzhaber and confirmation by the Oregon State Senate to a dentist seat on the OBD.

Dr. Beck has a B.S. degree in Microbiology from Montana State University and received his D.M.D. degree from OHSU. He has practiced dentistry since 1995, and has also been teaching at OHSU since 1999. He enjoys volunteering and has helped with various groups; currently with Medical Teams International.

He is the immediate past President of the Multnomah County Dental Society, past board member of the Oregon Academy of General Dentistry and current Educational Liaison and past Chair of the ODA’s Dental Health and Wellbeing Committee.



James Morris of Portland joined the Board in April 2013 following his appointment by Governor Kitzhaber and confirmation by the Oregon State Senate to a public member seat on the OBD.

Mr. Morris is a Financial Representative with Northwestern Mutual Financial, and has an extensive business background including owning his own business. Mr. Morris is married to Amalia Morris. He is a commissioner on Oregon’s Commission on Black Affairs. He proudly served in the US Air Force and served during the first Gulf War. He is active in his church, works with various charitable groups and is on the Board of Directors for the Oregon League of Minority Voters.



Matt Tripp, R.D.H., of Grants Pass joined the Board in May 2013 following his appointment by Governor Kitzhaber and confirmation by the Oregon State Senate to a dental hygienist seat on the OBD.

He has worked as a dental hygienist since 2009. Mr. Tripp graduated from the dental hygiene program at Clark College. Mr. Tripp was a US Marine, and also worked as a police officer in Grants Pass. He was the first dental hygienist in Oregon to have a fully functioning mobile dental hygiene clinic and is proud to serve disadvantaged communities.

BOARD MEMBERS	
<p>Jonna Hongo, DMD President <i>Portland</i> Term expires 2016</p> <p>•</p>	<p>Norman Magnuson, DDS <i>Eugene</i> Term expires 2014</p> <p>•</p>
<p>Brandon Schwindt, DMD Vice President <i>Tigard</i> Term expires 2017</p> <p>•</p>	<p>Julie Ann Smith, DDS, MD <i>Portland</i> Term expires 2015</p> <p>•</p>
<p>Patricia Parker, DMD <i>Hillsboro</i> Term expires 2014</p> <p>•</p>	<p>John “Matt” Tripp, RDH, EPP <i>Grants Pass</i> Term expires 2017</p> <p>•</p>
<p>Mary Davidson, MPH, RDH, EPP <i>The Dalles</i> Term expires 2014</p> <p>•</p>	<p>Todd Beck, DMD <i>Portland</i> Term expires 2017</p> <p>•</p>
<p>Alton Harvey, Sr. <i>Public Member, Beaverton</i> Term expires 2014</p>	<p>James Morris <i>Public Member; Portland</i> Term expires 2017</p>

## DISCIPLINARY ACTIONS TAKEN BETWEEN JANUARY 1, 2013 AND SEPTEMBER 30, 2013

*The following reports of Board actions have been edited for clarity and brevity. The actual documents may be viewed on the Board's website.*

### Unacceptable Patient Care ORS 679.140(1)(e)

**Case #2012-0149** The Board issued a Notice of Proposed Disciplinary Action alleging that between January 2011 and February 2012, Ian M. Erickson, D.M.D., permitted a dental assistant to expose radiographs without being certified to do so. In a Consent Order, Dr. Erickson agreed to be reprimanded.

**Case #2012-0158** The Board issued a Notice of Proposed Disciplinary Action alleging that between January 2011 and February 2012, Nicole Keck-Erickson, D.M.D., permitted a dental assistant to expose radiographs without being certified to do so. In a Consent Order, Dr. Keck-Erickson agreed to be reprimanded.

**Case #2011-0172** The Board issued a Notice of Proposed Disciplinary Action alleging that Charles R. Staley, D.M.D., failed to document obtaining informed consent; failed to document treatment that was provided; failed to document a dental diagnosis of caries evident on radiographs on numerous teeth; failed to document a dental justification prior to providing various treatments; and utilized Nitrous Oxide Sedation but failed to document the patient's vital signs and the patient's condition upon discharge. In a Consent Order, Dr. Staley agreed to be reprimanded and to pay a \$5,000.00 civil penalty.

**Case #2012-0146** The Board issued an Amended Notice of Proposed Disciplinary Action alleging that between January 23, 2012 and March 17, 2012 Anthony B. Bouneff, D.M.D. failed to maintain current Advanced Cardiac Life Support (ACLS) certification while providing General Anesthesia to his patients. In a Consent Order, Dr. Bouneff agreed to be reprimanded and

to pay a \$5,000.00 civil penalty.

**Case #2012-0010** The Board issued a Notice of Proposed Disciplinary Action alleging that Chris Y. J. Lee, D.M.D., failed to document that five radiographs were taken; failed to document obtaining informed consent; failed to document a diagnosis and dental justification for providing periodontal maintenance therapy; and placed an implant in the #7 area that was placed too far facially and too far apically. In a Consent Order, Dr. Lee agreed to be reprimanded, to complete three hours of Board approved CE in record keeping, and to cease placing dental implants pending further Order of the Board.

**Case #2011-0074** The Board issued a notice of Proposed Disciplinary Action alleging that Keith G. Martel, D.D.S., failed to document obtaining informed consent; failed to diagnose and document an open-bite as a treatment complication following the placement of an anterior ramp TMJ splint; and then failed to refer the patient to an Orthodontist. In a Consent Order, Dr. Martel agreed to be reprimanded and to pay a \$5,000.00 civil penalty.

**Case #2013-0081** The Board issued a Notice of Proposed Disciplinary Action alleging that between 2006 and 2012, Steven W. Black, D.D.S., permitted a dental assistant to expose radiographs without being certified to do so. In a Consent Order, Dr. Black agreed to be reprimanded.

**Case #2011-0226** The Board issued a Notice of Proposed Disciplinary Action alleging that John A. Hendy, D.D.S., failed to document that a radiograph was taken and failed to document a diagnosis of excess cement on the distal of a tooth or any attempt to remove the excess cement that was evident on the radiograph that was taken. In a Consent Order, Dr. Hendy agreed to make a restitution payment of \$4,334.00 to the patient.

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**DISCIPLINARY ACTIONS** (Continued from page 4)

**Case #2012-0224** The Board issued a Notice of Proposed Disciplinary Action alleging that Alireza F. Bolouri, D.M.D., while treating a patient utilizing Conscious Sedation failed to document the patient's vital signs, that a pulse oximeter was utilized, and the patient's condition upon discharge; chose to utilize a 13 millimeter long implant in the #19 extraction site area without first obtaining adequate pretreatment diagnostic radiographs of an area where there was a significant risk of intruding on the mandibular canal when using an implant of that length; and failed to refer the patient to a specialist when the patient returned with symptoms of numbness and the radiograph taken on that date showed possible intrusion of the #19 implant into the mandibular canal. In a Consent Order, Dr. Bolouri agreed to be reprimanded, to complete three hours of Board approved CE in record keeping, and to cease placing dental implants until completion of the Board approved 21-hour course "Implant Mentoring 1" or a comparable course that includes hands-on-training.

**Case #2012-0077** The Board issued a Notice of Proposed Disciplinary Action alleging that Hanna Karlin, D.M.D., failed to document obtaining oral informed consent; failed to document that diagnostic testing was done; failed to document that a prescription for Amoxicillin was written; failed to document the extrusion of gutta percha past the apex of the distal root of tooth #18 that occurred while providing endodontic therapy to tooth #18; failed to document the name, quantity of, or dosage of the antibiotic premedication that the patient was previously prescribed and had taken prior to these appointments; failed to document permanently seating eight crowns; and permanently seated a crown that had an open distal margin on a tooth. In a Consent Order, Dr. Karlin agreed to be reprimanded, to complete three hours of Board approved CE in record keeping, and to make a restitution of \$961.00 to the patient.

**Case #2012-0083 and 2012-0167** The Board issued a Notice of Proposed Disciplinary Action alleging that Timothy W. Burns, D.D.S.,

while treating multiple patients, failed to document obtaining informed consent; examined and approved the cementation of a temporary crown on a tooth but the crown that the patient left the licensee's office with had excess temporary cement left on the distal interproximal area of the tooth that was evident in a radiograph taken on that date; examined and approved the cementation of a temporary crown on a tooth but the crown that the patient left the licensee's office with was ill fitting with overhanging margins, and excess temporary cement was left in the mesial and distal interproximal areas of the tooth; failed to diagnose and document in the patient records a diagnosis of caries in numerous teeth although the patient's radiographs showed those deficiencies; failed to document a diagnosis and dental justification for placing restorations in numerous teeth; and placed restorations in numerous teeth, but the cavity preparations were too shallow occlusally, failed to break through the interproximal contacts, and the gingival margins were not placed below the interproximal contacts to allow for access for finishing of the margins. In a Consent Order, Dr. Burns agreed to be reprimanded, to make a restitution payment of \$2,236.00 to the patient, and to apply through the Oregon Academy of General Dentistry (OAGD) for entry into the board's Mentor Program, to successfully complete the Board/OAGD Mentor Program at his expense, and to attain an acceptable level of skill in record keeping, diagnosis and treatment planning, and the treatment of pediatric patients.

**Case #2012-0203** Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

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**DISCIPLINARY ACTIONS** (Continued from page 5)

Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

**Case #2012-0039** The Board issued a Notice of Proposed Disciplinary Action alleging that, on seven dates between June 20, 2011 and September 3, 2011, Jeffrey B. McAtee, D.M.D., prescribed Hydrocodone and Acetaminophen, a Class III Scheduled drug, in amounts that constituted departure from the prevailing standards of acceptable dental practice; and on nine dates between May 22, 2011 and September 3, 2011, prescribed Hydrocodone and Acetaminophen and failed to document the prescriptions in the patient record. In a Consent Order, Dr. McAtee agreed to be reprimanded, to pay a \$1,000.00 civil penalty, and to complete three hours of Board pre-approved CE in record keeping.

**Case #2012-0148** The Board issued a Notice of Proposed Disciplinary Action alleging that between 2009 and 2012, Kathy S. Kim, D.D.S., permitted a dental assistant to expose radiographs without being certified to do so. In a Consent Order, Dr. Kim agreed to be reprimanded and to pay a \$2,500.00 civil penalty.

**Case #2009-0253** The Board issued a Notice of Proposed Disciplinary Action alleging that Stephen P. Schwam, D.D.S., failed to accurately document a diagnosis prior to initiating orthodontic treatment; failed to refer the patient for orthodontic treatment when the welfare of the patient would have been safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; failed to document periodontal charting on the lower right quadrant prior to initiating periodontal treatment in the lower right quadrant; failed to document the quantity and strength of the whitening agent that he dispensed; obtained a fee by fraud or misrepresentation when he charged the patient \$2,500.00 for removable appliance therapy which he never delivered; and failed to provide copies of records to the patient within 14 days of written request. In a Consent Order, Dr. Schwam agreed to be reprimanded, to make a restitution

payment of \$9,936.00 to the patient, to only provide orthodontic treatment under the close supervision of a Board approved Orthodontist, to have the Orthodontist review and co-sign all diagnoses, treatment plans, and treatment notes, to maintain a log of all orthodontic procedures done, to have the Orthodontist provide a written report to the Board every six months, and to successfully complete at least five orthodontic cases prior to the removal of this license restriction.

**Case #2011-0012** The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Darren Huddleston, D.M.D., prior to initiating treatment of a patient failed to obtain a diagnostic wax-up that would have allowed him to recognize the proposed cosmetic treatment sought by the patient of teeth #'s 6, 8, 9, and 11, without simultaneously including teeth #'s 7 and 10, was not possible to achieve; when he agreed to change the treatment plan to omit teeth #'s 7 and 10 per her request, failed to recognize and then inform her that shifting her midline 1.5mm would result in the placement of restorations with a significant size discrepancy; failed to document on which teeth numbers preparations were refined; and failed to document certain elements of treatment. In a Consent Order, Dr. Huddleston agreed to be reprimanded and to make a restitution payment of \$1,850.00 to the patient.

**Case #2012-0099** The Board issued a Notice of Proposed Disciplinary Action alleging that Kevin K. Shim, D.D.S., while providing minimal sedation to a patient, failed to document that a pulse oximeter was used; failed to document obtaining informed consent; failed to document the patient's condition upon discharge; and induced Minimal Sedation without first obtaining a Minimal Sedation permit. In a Consent Order, Dr. Shim agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

**Case #2012-0138** Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

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**DISCIPLINARY ACTIONS** (Continued from page 6)

Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

**Case #2010-0186** The Board issued a Notice of Proposed Disciplinary Action alleging that Michael C. Regan, D.M.D., failed on five occasions to document a dental diagnosis to justify the prescriptions given to a patient; placed implants in the maxilla of a patient and failed to recognize the perforation of the maxillary sinus of the patient and record that complication in the patient record; placed implants into the maxilla of a patient that were poorly positioned, poorly angled and misaligned resulting in poor retention and easy displacement of the maxillary denture licensee constructed; on the Board's 2012-2014 online License and Permit Renewal Application dated February 8, 2012, deceived the Board by falsely answering, "No," to the application question, "Since the date of your last license application (initial or renewal), has there been any written request to you, your malpractice insurance company, or risk retention group regarding an alleged injury that may have been caused by your professional negligence, or any written notification from you to your malpractice insurance company or risk retention group that a person has made a request from you for an alleged injury caused by your professional negligence?" when, in fact, he was notified by letter dated October 12, 2010, that he had breached the standard of care resulting in a claim for past, present, and future injuries to patient CC, which resulted in a settlement payment by Licensee's malpractice insurance company to a patient in the amount of \$72,000.00 and on March 29, 2011 his settlement was reported to the National Practitioner Data Bank. In a Consent Order, Dr. Regan agreed to be reprimanded, to pay a \$2,000.00 civil penalty, and to complete three hours of Board approved CE in record keeping.

**Case #2012-0164** The Board issued a Notice of Proposed Disciplinary Action alleging that William J. Breen, D.D.S., seated a bridge on teeth #'s 12 and 14 and failed to diagnose and

document that the crown on tooth #14 had overhanging mesial and distal margins; failed to diagnose and document in the patient records the presence of an overhanging distal margin on the crown on tooth #14 although the patient's radiographs taken on that date showed the deficiency; failed to complete the 40 hours of continuing education required for renewal of his dental license; and on January 23, 2012 made an untrue statement on his application for renewal of his license to practice dentistry in Oregon for the April 1, 2012 - March 31, 2014 licensing period when he declared and signed his application certifying that between April 1, 2010 through March 31, 2012 he had completed or would complete the required continuing education hours required for renewal of his dental license. In a Consent Order, Dr. Breen agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

**Case #2013-0165** The Board issued a Notice of Proposed Disciplinary Action alleging that Keith F. Ogawa, D.D.S., failed to document obtaining informed consent; while utilizing Nitrous Oxide Sedation, failed to take and document the patient's vital signs and the amount of Nitrous Oxide administered and also failed to document the patient's condition upon discharge; re-cemented a temporary crown but did not document in the patient records on which tooth the temporary crown was re-cemented; took CAT scans but failed to document in the patient records that the CAT scans were taken; took two periapical radiographs but failed to document in the patient records that the radiographs were taken; and failed to refer the patient to a specialist when the implant in the #4 area was displaced into the right maxillary sinus. In a Consent Order, Dr. Ogawa agreed to be reprimanded, to complete three hours of Board approved continuing education courses in record keeping, complete the Board Mentor Program in implant placement at his expense, and to make a restitution payment in the amount of \$8,338.50 to the patient.

**Case #2011-0091** The Board issued a Notice of Proposed Disciplinary Action alleging that John A. Hendy, D.D.S., failed to document in

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**DISCIPLINARY ACTIONS** (Continued from page 7)

the patient record the strengths of Valium and Halcion that were dispensed; failed to document the strength of Epinephrine in the anesthetics administered to the patient; failed to hold a current ACLS certificate to maintain Licensee's Deep Sedation Permit privileges while sedating a patient; failed to document in the patient record the strengths of Valium and Halcion that were dispensed to a patient; between January 1, 2010, and January 31, 2012, failed to maintain a current and constant inventory of all controlled substances; and by renewal application dated March 19, 2012, falsely certified that he had maintained a current and valid ACLS certificate for the licensure period April 1, 2010 to March 31, 2012. In a Consent Order, Dr. Hendy agreed to be reprimanded and to pay a \$2,500.00 civil penalty.

**Case #2013-0139** Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

**Case #2013-0163** The Board issued a Notice of Proposed Disciplinary Action alleging that Joel Fast, D.M.D., administered Nitrous Oxide without having first obtained a Nitrous Oxide permit from the Oregon Board of Dentistry; failed to document the name of the treatment provider who administered Nitrous Oxide to a patient; failed to document in the patient record that pre-treatment vital signs were taken when Nitrous Oxide was administered to a patient; and when questioned by an agent of the Board during a recorded interview, he denied that he administered Nitrous Oxide to a patient, when, in fact, he did administer Nitrous Oxide to the patient. In a Consent Order, Dr. Fast agreed to be reprimanded and to pay a \$5,000.00 civil penalty.

**Case #2013-0193** The Board issued a Notice of Proposed Disciplinary Action alleging that

Karl E. Schneck, D.D.S., on various dates, failed to maintain the integrity of disposable gloves when he cut the fingertips from the gloves and placed fingers in the mouths of numerous patients during endodontic therapy. In a Consent Order, Dr. Schneck agreed to be reprimanded.

**Case #2014-0007** The Board issued a Notice of Proposed Disciplinary Action alleging that Jason I. Yoon, D.M.D., administered Nitrous Oxide without having first obtained a Nitrous Oxide permit from the Oregon Board of Dentistry; failed to document in a patient record that pre-treatment vital signs were taken when Nitrous Oxide was administered to several patients; failed to document in the patient record the amount of Nitrous Oxide administered and the patient's condition upon discharge when Nitrous Oxide was administered to several patients; and failed to document in the patient records a dental justification for prescribing medication. In a Consent Order, Dr. Yoon agreed to be reprimanded, to complete three hours of Board approved CE in record keeping, to pay a \$5,000.00 civil penalty, and to complete a board approved Nitrous Oxide Sedation course and apply for a Nitrous Oxide permit.

**Case #2009-0275** Following an Administrative Hearing on the allegations that Robert L. Rodriguez, Jr., D.M.D., failed to document a dental justification for prescribing medication; failed to document obtaining informed consent, and failed to document a diagnosis to support a proposed treatment plan and subsequent treatment, the board issued a Final Order reprimanding Dr. Rodriguez, requiring the completion of three hours of Board approved CE in record keeping and three hours of Board approved CE in dental risk management, and to reimburse the Board the cost of \$7,197.23 for the disciplinary proceedings.

**Case #2012-0152** Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

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**DISCIPLINARY ACTIONS** (Continued from page 8)

Pursuant to SB1519 Chapter 16 (2014 Laws) this information has been removed. Please contact the Board office for further information.

**Case #2012-0153** The Board issued a Notice of Proposed Disciplinary Action alleging that Richard W. Davenport, D.M.D., failed to diagnose, document in the patient records and inform the patient that there was a separated instrument in the mesial canal of tooth #18, a separated instrument that was evident in radiographs. In a Consent Order, Dr. Davenport agreed to be reprimanded.

**Case #2013-0185 and 2013-0121** The Board issued a Notice of Proposed Disciplinary Action alleging that Mary K. Harrell, D.M.D., while treating a patient with a medical history of a heart valve replacement and being on a Coumadin regimen, attempted to extract tooth #1 without first obtaining medical clearance; failed to document in the patient records and inform the patient that a fracture of the right Maxillary Tuberosity and a perforation of the right Maxillary Sinus had occurred while extracting tooth #1; attempted to extract tooth #31, but when the licensee was unable to remove the root tips, failed to seek consultation and failed to refer the patient to someone with special skills, knowledge and experience to complete the procedure; failed to diagnose, document in the patient records, and inform the patient that while attempting to extract tooth #12 the licensee left a retained root tip; failed to diagnose, document in the patient records and inform the patient that while attempting to extract tooth #30 the licensee left a retained root tip; attempted to extract teeth #'s 2 and 4, but when she was unable to remove the retained root tips, failed to seek consultation and failed to refer the patient to someone with special skills, knowledge and experience to complete the procedure; prior to extracting tooth #17, she failed to first obtain a radiograph showing the periapical area of tooth #17; attempted to extract teeth #'s 17 and 20, but when she was

unable to remove the retained root tip of tooth #20, she failed to seek consultation and failed to refer the patient to someone with special skills, knowledge and experience to complete the procedure. In a Consent Order, Dr. Harrell agreed to be reprimanded; to complete three hours of Board approved continuing education courses in record keeping; to complete four hours of Board approved continuing education courses in treating the medically compromised patient; to complete 16 hours of Board approved continuing education courses in simple extractions, surgical extractions, extraction complications, and root removal; and to be prohibited from doing any extractions of teeth until completion of a Board approved Mentor Program focused on extractions at her expense.

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

**Case #2009-0105** The Board issued an Order of Immediate Emergency License Suspension for Shelly R. Huser, R.D.H., based on the nature and history of Ms. Huser's alcohol abuse; false statements made in order to deceive the Board; violation of the terms of a Board Order for Examination, dated June 5, 2012; the diagnosis of alcohol dependence by a Board approved provider; Ms. Huser's continued denial of an alcohol problem; and the failure of Ms. Huser to enter a recommended treatment regimen. In a Consent Order, Ms. Huser agreed to have her dental hygiene license reinstated, to be reprimanded, to surrender her board issued Expanded Practice Permit, surrender the instructor permits issued by the Board, and agree not to reapply for an instructor permit, to provide 80 hours of Board approved community service, to not use alcohol, illegal drugs, Scheduled controlled drugs, or mood altering substances at any place or time, unless Scheduled drugs are prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, advise the Board, within 72 hours, of any alcohol, illegal or prescription drug, or mind altering

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**DISCIPLINARY ACTIONS** (Continued from page 9)

substance related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program, to enter into the State's Health Professionals' Services Program (HPSP) and abide by the program's requirements, and to appear before the Board three times a year.

**Unprofessional Conduct**  
**ORS 679.140(1)(c)**

**Case #2012-0173** The Board issued a Notice of Proposed Disciplinary Action alleging that Elisabeth J. Martin, R.D.H., failed to complete the 24 hours of Board required continuing education for the 2009-2011 licensure period and twice failed to respond to the Board's request for information within 10 days of a written request. In a Consent Order, Ms. Martin agreed to be reprimanded and to pay a \$2,500.00 civil penalty or to complete 50 hours of Board approved pro bono community service.

**Case #2012-0192** The Board issued a Notice of Proposed Disciplinary Action alleging that Cynthia K. Baumgardner, R.D.H., failed to maintain records of successful completion of 24 hours of Board required CE between October 1, 2008 and September 30, 2010 and failed to provide proof of Board required CE between October 1, 2008 and September 30, 2010. In a Consent Order Ms. Baumgardner agreed to be reprimanded and to complete 20 hours of Board approved community service.

**Case #2013-0097 and 2013-0119** The Board issued a Notice of Proposed License Suspension alleging that Grant M. Smith, D.D.S., between December 31, 2012 and January 10, 2013, failed to respond to a written Board request for patient records, continuing education records, a copy of his current BLS/CPR certificate, and a written narrative related to patient care; on some date on or before January 16, 2013, he violated US Federal law when he wrote a prescription for 30 Percocet, a brand name for Oxycodone and

Acetaminophen, a Scheduled II controlled drug, for a patient and dated the prescription January 18, 2013; on some date on or before January 16, 2013, violated US Federal law when he wrote a prescription for 30 Norco, a brand name for Hydrocodone and Acetaminophen, a Schedule III controlled drug, for a patient, and dated the prescription January 22, 2013; between January 24, 2013 and February 4, 2013, failed to respond to a written Board request for patient records, continuing education records, a copy of his current BLS/CPR certificate, and documentation verifying installation of an amalgam separator; between April 12, 2013 and April 23, 2013, failed to respond to a written Board request for patient records, continuing education records, a copy of his current BLS/CPR certificate, documentation verifying installation of an amalgam separator and a written narrative explaining why he did not respond to the January 24, 2013 request for information; and between May 7, 2013 and May 18, 2013 failed to respond to a written Board request for patient records, continuing education records, a copy of his current BLS/CPR certificate, and a written narrative related to patient care. Dr. Smith failed to request a hearing in a timely manner, so in a Final Default Order, Dr. Smith's dental license was indefinitely suspended.

**Case #2012-0177** The Board issued a Notice of Proposed License Suspension alleging that Anthony J. Lewis, R.D.H., by the Board's electronic License and Permit Renewal Application, dated 8/26/10, applied for renewal of his dental hygiene license and on the application, falsely confirmed by answering "Yes" to the application statement, "I have completed, or will complete by 9/30/2010, the 24 hours of continuing education required for licensure period 10/1/08 to 9/30/10, including THREE (3) hours related to medical emergencies in the dental office," when he had completed only 21 hours for the licensure period; on or about November 16, 2011, had offensive physical contact for sexual purposes while treating an adult female patient; on or about April 11, 2012, he had offensive physical contact for sexual purposes while he treated an adult female patient;

(continued on page 11)

**DISCIPLINARY ACTIONS** (Continued from page 10)

and by Petition to Plead Guilty, dated January 4, 2013 and filed in The Circuit Court of the State of Oregon for the County of Malheur, he pled guilty to two counts of harassment-sexual/Class A Misdemeanor, for offensive physical contact for sexual purposes while he treated adult female patients. Mr. Lewis failed to request a hearing in a timely manner, so in a Final Default Order, Mr. Lewis' dental hygiene license was revoked.

**Prohibited Practices  
ORS 679.170(6)**

**Case #2013-0107** The Board issued a Notice of Proposed Disciplinary Action alleging that Madrid Uso, III, D.D.S., between April 1, 2009 and March 31, 2013, failed to maintain records of successful completion of 40 hours of continuing education for the licensure period April 1, 2009 to March 31, 2011; between November 1, 2012 and November 15, 2012, failed to respond to a written Board request for patient records; and between December 13, 2012 and December 23, 2012 failed to respond to a written Board request for patient records, a written narrative, continuing education records, a copy of his contract with River City Denture and Dental, and his Healthcare Provider CPR card. In a Consent Order, Dr. Uso agreed to be reprimanded, to pay a \$1,000.00 civil penalty, and to submit, with his 2015-2017 License and Permit Renewal Application, documentation verifying completion of 40 hours of continuing education for the licensure period April 1, 2013 to March 31, 2015.

**2013 LEGISLATIVE SESSION  
HB 2124**

**OAR 818-013-0001 Health Professionals' Services Program** Eliminates a self-referral to the HPSP. **Effective 1/1/14**

**OAR 818-013-0005 Health Professionals' Services Program** Eliminates a self-referral to the HPSP. **Effective 1/1/14**

**OBD RULE CHANGES**

The Oregon Board of Dentistry and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended. OARs are written and amended within the agency's statutory authority granted by the Legislature.

In 2013 we amended our rules twice (spring and fall) and implemented one Temporary Rule. Official Notice of rulemaking is provided in the Secretary of State's *BULLETIN*. The full text of the OARs and information on public rulemaking hearings can be found at our Website: <http://www.oregon.gov/dentistry>. Due to space constraints in this newsletter, a *brief summary* is provided.

**OAR 818-001-0002 Definitions** Clarifies the term 'Dentist of Record' for the treatment of patients in clinical settings of the institution as described in ORS 679.020(3). **Effective 7/1/13**

**OAR 818-001-0087 Fees** Clarifies the fees for specialty dental exams. **Effective 7/1/13**

**OAR 818-012-0005 Scope of Practice** (*This OAR was amended twice in 2013.*) Corrects a lettering mistake. **Effective 7/1/13** Also, amended the rule to clarify the training a dentist needs to use Botulinum Toxin Type A within the scope of the practice of dentistry. **Effective 1/1/14**

**OAR 818-026-0000 Purpose** Removes language from the rule that had designated where sedation could occur. **Effective 7/1/13**

**OAR 818-026-0020 Presumption of Degree of Central Nervous System Depression** Addresses sedation on children six years or younger; that the licensee must have the appropriate sedation permit to administer. **Effective 7/1/13**

**OAR 818-026-0140 (TEMPORARY RULE) Implementation Date of End Tidal CO<sub>2</sub> Monitoring** The requirement to have patients continuously monitored with End-tidal CO<sub>2</sub> monitors as provided in OAR 818-026-0060(7)(a),

(continued on page 12)

**RULE CHANGES**

(Continued from page 11)

OAR 818-026-0065(7)(a) and OAR 818-026-0070(7)(a) will become effective on December 29, 2013. **Effective 7/1/13**

**OAR 818-026-0060 Moderate Sedation Permit** (*This OAR was amended twice in 2013.*) Adds the requirement of using End-tidal CO2 Monitors to administer sedation. **Effective 7/1/13** Also amended 1(A) to clarify which Part of the ADA Guidelines referenced in rule. **Effective 1/1/14**

**OAR 818-026-0065 Deep Sedation Permit** Clarifies that no permit holder shall have more than one person under any type of sedation at the same time and adds the equipment requirements of an electrocardiograph monitor and an End-tidal CO2 Monitor. **Effective 7/1/13**

**OAR 818-026-0065(2)(h) and (7)(a) Deep Sedation Permit** Adds the equipment requirements of an electrocardiograph monitor and an End-tidal CO2 Monitor. **Effective 7/1/13**

**OAR 818-026-0070 General Anesthesia Permit** Adds the equipment requirements of using pulse oximetry, electrocardiograph monitor and an End-tidal CO2 Monitor. **Effective 7/1/13**

**OAR 818-035-0020 Authorization to Practice** Clarifies the duties a hygienist may perform. **Effective 7/1/13**

**OAR 818-035-0066 Additional Populations for Expanded Practice Dental Hygiene Permit Holders** Adds designated Dental Health Professional Shortage Areas (DHPSA) to list of populations to be served. **Effective 7/1/13**

**OAR 818-035-0072 Restorative Functions of Dental Hygienists** Deletes the word anterior from rule. **Effective 7/1/13**

**OAR 818-042-0090 Additional Functions of EFDAs** Allows hygienists to authorize EFDAs to apply sealants and soft relines. **Effective 7/1/13**

**OAR 818-042-0095 Restorative Functions of Dental Assistants** Deletes the word anterior from the rule. **Effective 7/1/13**

**OAR 818-042-0110 Certification - Expanded Function Orthodontic Assistant** Clarifies the on-the-job requirement with using headgear, removal of orthodontic appliances and impressions. **Effective 7/1/13**

**OAR 818-012-0040 Infection Control Guidelines** Clarifies the record keeping requirements for sterilization equipment. **Effective 1/1/14**

**OAR 818-042-0060 Certification-Radiologic Proficiency** Adds digital radiographs as an option to become radiologic proficient for dental assistants. **Effective 1/1/14**

## **BOARD OF DENTISTRY CLARIFIES RULE ON GIFTS FOR REFERRALS**

Giving a small token of appreciation after a referral has been completed does not constitute fee splitting. The Board makes a distinction between an “expected” gift and an unexpected thank you. Expected gifts are those in which a dental office advises patients or other dentists ahead of time that they will give a gift for referring a new patient. This is considered a form of fee splitting.

For example, suppose a dentist tells patients that they will receive \$75 off their bill or a \$50 gift certificate to a restaurant for referring a new patient. This is a form of fee splitting because it is an oral contract between the dentist and the patient to deliver compensation for the referral; the patient expects to receive the credit or gift certificate.

The Board has stated that unanticipated gifts of a nominal nature are acceptable, such as a thank you card and a coffee mug, flowers, Starbucks card, or other item of token value. The important distinction is whether the gift was advertised ahead of time to the referring party -- irrespective of whether that party is a patient or a dentist. Advance notice has the potential to influence referrals and thus violates the rule against fee splitting.

If you have further questions about this issue, please feel free to contact the OBD at (971) 673-3200 or at [information@oregondentistry.org](mailto:information@oregondentistry.org). ■

## OREGON PAIN MANAGEMENT COMMISSION UPDATE

by *Kathy Kirk, RN, BS*  
*Pain Management Coordinator*  
*Oregon Health Policy and Research*  
*Oregon Pain Management Commission*

When the Oregon Pain Management Commission (OPMC) was established, it was directed by Oregon Revised Statute to provide one hour of Oregon specific pain management training for certain health care professionals. Dentists are required to complete this training one time as a requirement for their application to be re-licensed to practice in Oregon. To meet this obligation, the OPMC developed a module, titled “Advancing Pain Management in Oregon.” This pain management module has been newly revised and is available online: <http://www.oregon.gov/oha/OHPR/Pages/pmc/index.aspx>. (Click on PDF or Word version link under “Pain Management Module” banner.)

Although many professionals have already completed this pain management training requirement, the OPMC is encouraging all health care professionals to review the newly updated module. Below I provide some information about the updates.

OPMC commission members have diligently worked to improve the pain management information included in the training “Advancing Pain Management in Oregon.” There is approximately thirty percent new information included in the updated module. New topics include: pain assessment; appropriate standards to care for use of opioids in pain management; universal precautions in pain medicine; modifiable life factors that affect each other and pain; dentists and pain management; health care professional communication with clients and other providers; health care professional ethical obligations; information assimilated from the Institute of Medicine’s 2011 report titled “Relieving Pain in America;” a link to the OPMC Position Statement on medical marijuana use; information about and a link to the Oregon Prescription Drug Monitoring Program; and information about and a link to the 2013 Oregon Medical Board’s Pain Management Statement of Philosophy. In addition, other sections -- including the OPMC conclusion and recommendations -- were updated and outdated information was removed from the module. It should be obvious that some significant new pain management topics have been included in the updated module. This revised module and new links will give health care professionals additional information to use in managing people with pain. ■

## BOARD STAFF

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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.

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](mailto:information@oregondentistry.org).

## FAILING TO RELEASE PATIENT RECORDS

**OAR 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.

**OREGON BOARD OF DENTISTRY**  
 1500 SW 1<sup>st</sup> Avenue, Suite 770  
 Portland, OR 97201

**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 website at [www.oregon.gov/dentistry](http://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.*



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

**CHANGE OF ADDRESS FORM**

Licensee Name: \_\_\_\_\_  
Print Name Phone

Licensee Number: \_\_\_\_\_

New Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_

New Email Address: \_\_\_\_\_

Above is designated as my mailing address:  Home  Office  Other

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