



OREGON BOARD of DENTISTRY

NEWS

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December 2008

PRESIDENT'S MESSAGE

by Darren S. Huddleston, D.M.D.
President 2008-2009



I am truly honored to be serving as President of the Board of Dentistry for the term 2008-2009. This is my first term on the Board and I must say I have learned a lot over the past three years. When I first

learned that my name was forwarded to the Governor's Office as a potential Board candidate, I thought it was a nice gesture but a long shot. I knew I could do a good job but I thought others could potentially frown upon my five years of professional experience. So I was surprised to learn that the Governor accepted my nomination and that the Senate confirmed my appointment.

The surprise quickly turned to reality when the first 500-page notebook full of complaint cases came in the mail. It is hard to comprehend the task load unless you are a Board member, and initially I had no idea how the complaint process worked. Prior to being on the Board, I would

hear stories and rumors about the brashness of the Board. But I have been very impressed with the professional and fair manner in which the Board handles each complaint.

In a nut shell, as each complaint is received, the Board is briefed on the preliminary nature of the issue. The complaint is then thoroughly investigated by our Board employees. These employees assemble the information in a comprehensive and responsible manner and then offer their recommendation. Two weeks prior to the regularly scheduled Board meeting, two Board members and Senior Assistant Attorney General Lori Lindley review all the cases and they also provide a recommendation. That recommendation may or may not coincide with the investigators' evaluation. One week prior to the Board meeting, all nine Board members receive their binders—actually, we've upgraded to electronic thumb drives—of Board cases and all the information is reviewed by each Board member. Then at the Board meeting, each case is discussed again and a final resolution is made.

As you can see, Board actions are all thoroughly discussed and evaluated by Board members many times. In this way, the process creates fair outcomes for all parties involved. Fortunately, many of these complaints warrant no action at all, but all complaints are thoroughly reviewed.

Following are a few of my recommendations for my esteemed colleagues. These things are addressed frequently in our Board meetings:

- PARQ appropriate chart entries
- Document a reason for every procedure done
- Renew your license on time and if you employ a dental hygienist, be sure they have also renewed on time

I am looking forward to a great year ahead of us. Thank you for your service to your patients and for your service to our profession. ■

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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.*

LIGHT AT THE END OF THE TUNNEL



*By Patrick D. Braatz,
Executive Director*

As you read this message the 2008 Election campaign will be history or as it has been referred to from my former home the “silly

season,” but next comes the real work.

The 2009 Legislative Session will start in January 2009 and there will be new proposed legislation to review and consider.

The Oregon Board of Dentistry (OBD) does not have specific legislation that it has requested be introduced, with the exception of the 2009-2011 Biennial Budget. The Budget has increased and we have requested some modest fee increases on new applications, but as I write this we are not sure if that request will be moved forward into the Governor’s Recommended Budget. The OBD has not raised any fees since 1999.

It is expected that a number of legislative bills will be introduced that will have an impact on all Health Care Regulatory Licensing Boards in Oregon and as a licensee you should be very interested in those proposals.

There will be a proposal to make Health Care Regulatory Licensing Boards more uniform. The proposals will be that all Board members should be appointed by the Governor, confirmed by the Oregon State Senate, and serve four year terms. The number of terms that they could serve would not have a limit. There will also be a proposal to raise the current \$30 a day compensation to a higher amount based on each of the Health Care Regulatory Licensing Boards’ Budget.

There will be another proposal that would require that all Health Care Regulatory Licensing Boards have at least 50% minus one public members and the size of the Board would not increase. This would mean that the OBD would lose two dental members and one dental hygiene member. The OBD does not believe that this change is in the best interest of the citizens of Oregon and the members of the Legislature need to hear from licensees if they don’t agree with this change.

Another proposal would be to remove from the OBD the very successful Confidential Diversion Program that the OBD created four years ago and place it within another state agency. Again, the OBD does not believe that this proposal will cause those that need this program the most to seek the help that they need, as the program will no longer be under the control of the OBD.

Other proposals that might allow others to practice Dentistry and Dental Hygiene are looming on the horizon, but no one has shared those proposals with the OBD as of this newsletter.

I urge you to stay informed and to reach out to your Representatives and Senator to tell them your feelings on any 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 e-mail at Patrick.Braatz@state.or.us or by stopping by the OBD office in downtown Portland. ■

DENTAL RENEWAL NOTICES

Dental license renewal applications will be mailed out the week of January 12, 2009 to those dentists whose licenses expire on March 31, 2009. If you have not received your license renewal by January 31, 2009, please contact the Board office at (971) 673-3200 or e-mail the Board’s Licensing Manager at Teresa.Haynes@state.or.us so that a new renewal application can be sent.

Completed renewal applications must be received by March 20, 2009, to guarantee that your license is renewed by April 1, 2009. If the Board receives your completed renewal after March 20, 2009, the Board cannot guarantee your license will be renewed by April 1, and you cannot practice with an expired license. Practicing with an expired license can result in the Board taking disciplinary action. Before you begin to practice on April 1, 2009, check either the Board’s Web site at www.oregon.gov/dentistry or contact the Board office to make sure your license is renewed. ■

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. ■

BOARD MEMBERS

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Term expires 2009

Jill Mason, MPH, RDH
Vice-President
Portland
Term expires 2009

Melissa Grant, DMD
Vancouver/Salem
Term expires 2009

Mary Davidson, BS,
RDH, LAP
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Term expires 2010

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Eugene
Term expires 2010

Patricia Parker, DMD
Albany
Term expires 2010

Rodney Nichols, DMD
Milwaukie
Term expires 2011

Jonna Hongo, DMD
Portland
Term expires 2012

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

TOP 10 QUESTIONS ASKED BY DENTAL OFFICES!

by Beryl Fletcher, ODA Director
of Professional Affairs

- **How long do we need to keep records?**

The Oregon Board of Dentistry specifies at least seven years. ODA recommends that you also check with your liability carrier as some prefer to have you keep records longer.

- **If we don't send claims electronically, do we need to get an NPI Number?**

ODA and the ADA recommend that all providers obtain an NPI number. We have heard that some carriers may require them regardless of electronic submission. The new ADA claim form has a designated place to include the NPI Number. You will need an NPI if you file Medicare or Medicaid (OHP) claims.

- **Do you have a letter or advice on how to dismiss a patient?**

The American Dental Association has a publication “Dental Letters with Impact!” Contact ADA Saleable Materials 1-800-947-4746. This publication also includes other patient letters pertaining to other subjects within a dental practice: professional letters, letters for marketing the practice, employment and personal letters.

- **If doctor has taken his CPR class, does that qualify for risk management credit? What about medical emergencies classes?**

Risk management courses are relating to liability/malpractice insurance and are not the same as a CPR or medical emergencies course. Liability carriers usually sponsor these. Most of the local dental societies offer these at least once every three years and each year ODA offers a course at the Oregon Dental Conference in April.

Taking a risk management course is a requirement for ODA membership. Most liability carriers require the doctor to take a course. Some require the doctor to take their specific course. DBIC, for example, requires the doctor to take one of their courses in order to qualify for the annual dividend. Other carriers may require their course in order to qualify for a discounted premium.

The Board of Dentistry does not require risk

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management courses but does require medical emergencies and other courses dependent upon anesthesia permits and certifications.

- We are remodeling our office. Do we need to lower our counters in the reception area to comply with HIPAA? Are there HIPAA approved specifications for offices?

HIPAA (as well as OSHA) does not specify materials nor do they approve materials, cabinets, carpets or any other items. As far as lowering of countertops etc., this may be something to consider in a remodel of the office and would fall under the American with Disabilities Act. The disabilities act recommends that you make reasonable and feasible upgrades when remodeling. Check with your builder (who should have the specifications), as well as online at the U.S. Dept. of Justice website www.usdoj.gov/crt/ada/stdspdf.htm.

- Where can we get OSHA training for staff?

The ODA has some audiovisual materials that can be checked out from ODA provided the dentist is a member of the ODA. A listing of the audiovisual library is available on ODA's website at www.oregondental.org under "member resources." Go to resource guide under member resources and click and scroll to audiovisual library. You will need the doctor's ADA member number to access the member resources section of our website.

ODA offers classes at the annual Oregon Dental Conference. Oregon OSHA also offers classes around the state. Check with Oregon OSHA at <http://www.cbs.state.or.us/osha/education.html>.

- Where can I order a CDT code book?

This is available from the American Dental Association – Saleable Materials Dept. 1-800-947-4746. The CDT 2009 is now available in binder, spiral bound or on CD. There is also a CDT companion guide available that will help you to understand the codes and how to apply the code in clinical practice scenarios. It also will help with medical/dental code cross over.

- Our hygienist and/or dentist are doing a dental education piece at the local elementary school. Do you have some materials we can use?

The ODA has an audiovisual library available to members of the ODA. A listing of the audiovisual library materials is available on ODA's

website at www.oregondental.org. Look under member resources, then go to resource guide – click and then scroll to audiovisual library. You will need the doctor's ADA member number to access the member resources section of our website. There are also other handout and resource materials from the American Dental Association catalog www.ada.org. If you have questions or need further assistance, contact me at the ODA.

- Where can we dispose of our infectious wastes (sharps etc.)? Other wastes? Infectious waste such as sharps or blood soaked materials should be disposed of with a biohazard company and incinerated. Options for disposal include:

- Some local garbage services will provide a separate service to pick up sharps containers on a separate pick up from the regular garbage as they need to be handled and buried in a separate part of the landfill. Blood soaked materials or personal protective equipment must be disposed of with a medical waste/infectious waste/biohazard disposal company.
- Look up "Medical Waste or Bio-hazardous Waste" in the yellow pages of the telephone book.
- Contact METRO in Portland for one of their locations.
- Contact sponsor of local household hazardous waste events to see if they will accept this waste and the criteria for bringing it to the event.
- Query the internet for sharps mail back options and other medical waste disposal companies.
- Where can we get the posters we need to post in our office? Do we need to pay \$100 to a company to get them all?

Necessary posters that all employers must post are available free by downloading from the Oregon Bureau of Labor website at www.boli.state.or.us, then click on posters in the BOLI menu. You can also order from the Bureau of Labor for \$10 (not including shipping) an 8- in-1 poster that has most all posters needed. See ODA news article for additional postings needed. There is no need to order and pay a private company for posters required in Oregon businesses. ■

DISCIPLINARY ACTIONS TAKEN BETWEEN DECEMBER 1, 2007 AND SEPTEMBER 30, 2008

Unacceptable Patient Care ORS 679.140(1)(e)

Case #2007-0107 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist, while treating a patient, induced central nervous system sedation without a permit; while administering central nervous system sedation, failed to document in the patient's record the patient's condition upon discharge; while administering central nervous system sedation, failed to document in the patient's record pre-operative and post-operative blood pressure, pulse and respiration; failed to document in the patient's records "PARQ" or its equivalent after obtaining oral informed consent prior to providing treatment; failed to diagnose and document endodontically under filled MB and DB roots in tooth #14 and periapical pathology associated with the DB root of tooth #14 that were evident on a periapical radiograph taken; failed to document a diagnosis to justify initiating endodontic therapy on tooth #15; failed to diagnose and document endodontically under filled MB and DB roots in tooth #14 and periapical pathology associated with the DB root of tooth #14 that were evident on a periapical radiograph; failed to document a diagnosis to justify providing endodontic retreatment to tooth #15; allowed a dental hygienist without a Class 1 Permit to administer nitrous oxide sedation to patient TR; and failed to remove the root tip of the DB root of tooth #14 while extracting the tooth. 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 \$5,000.00 civil penalty.

Case #2007-0133 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 "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; failed to diagnose and document a diagnosis of dental caries in tooth #20, although a radiograph taken on June 5, 2006, that the Licensee reviewed on June 16, 2006, showed

recurrent dental caries in the tooth; failed to document a diagnosis to justify initiating endodontic therapy in tooth #19; failed to document and inform the patient of the short endodontic fills that were evident on a radiograph taken of tooth #19; failed to document in the patient records "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; seated a bridge #11 – 14, and failed to recognize that the anterior abutment of the bridge, tooth #11, had inadequate remaining tooth structure to serve as the anterior abutment of this four unit bridge. 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 have the Licensee's license to practice dentistry in the state of Oregon suspended, but stayed on the condition that Licensee applies through the Oregon Academy of General Dentistry (OAGD) for entry into the Board's mentoring program within 30 days of this Order; and to successfully complete the Board/OAGD mentoring program at Licensee's expense. Under the mentoring program, Licensee must attain an acceptable level of skill in record keeping, diagnosis and treatment planning, endodontic therapy and fixed prosthodontics; must remain in the mentoring program until such time as the mentor advises the Board that Licensee achieved an acceptable level of skill in the listed areas of dentistry, and the Board advises Licensee in writing that he met the provisions of this Order; within one year of the effective date of this Order, to attend and complete at least 16 hours of Board approved hands-on continuing education courses in fixed prosthodontics, at least 16 hours of Board approved hands-on continuing education courses in endodontic therapy, and at least three hours of Board approved continuing education courses in record keeping. The courses shall be approved in advance by the Board and shall be in addition to the Board's continuing education requirements for license renewal. Licensee shall submit to the Board, within one year of the effective date of this Order, documentation of successful completion of the continuing education required by this

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DISCIPLINARY ACTIONS (Continued from page 5)

Consent Order; and to discontinue providing all endodontic therapy and crown and bridge treatment until Licensee has enrolled in, or has completed, 16 hours of Board approved, hands-on continuing education in fixed prosthetics, 16 hours of Board approved, hands-on continuing education in endodontics therapy, and three hours of Board approved, continuing education in record keeping, and is actively engaged and participating in, the Board/OAGD mentoring program.

Case #2006-0104 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist placed a composite restoration in tooth #31 – MO, but failed to remove all the caries from the tooth prior to restoring the tooth; while using nitrous oxide failed to document in the patient record pre-operative and post-operative vital signs, dosage of gases administered, and patient's condition during and after treatment; prepared tooth #31 for a crown, but the preparation lacked adequate retention form; failed to document in the patient records a diagnosis to justify prescribing Clindamycin 300 mg X30; placed a composite restoration in tooth #18 – MODB that resulted in intrusion of the composite material into the pulp chamber of the tooth; on three occasions took dental radiographs and did an examination, but failed to diagnose and document the intrusion of composite material into the pulp chamber of tooth #18 and failed to diagnose and document the presence of subgingival calculus and bone loss on the distal root surface of tooth #18; failed to document in the patient records a diagnosis to justify initiating endodontic therapy in tooth #18; seated a crown on tooth #18, took a dental radiograph and did an examination, but failed to diagnose and document the presence of subgingival calculus and bone loss on the distal root surface of tooth #18 and a short mesial margin on the newly seated crown on tooth #18; documented in the patient record that the Licensee placed a composite restoration in tooth #2 – DO, when in fact, the Licensee did not place that restoration in that tooth; prepared tooth #29 for a DO composite restoration and the preparation for the restoration was deficient in that it had inadequate retention form and resulted in subsequent loss of the restoration; failed to

document in the patient records the name of the endodontic fill material that was used to endodontically treat tooth #18; initiated and completed endodontic therapy in teeth #s 18 and 19, and while doing so, the Licensee overfilled the distal canal of tooth #18 with gutta percha, but failed to diagnose and document the overfill in the patient records; failed to document in the patient records that the Licensee did buildups in teeth #s 13 and 15; prepared teeth #s 13, 14, and 15 for crowns, but for teeth #s 13 and 15, the Licensee placed the margins of the crown preparations on pre-existing composite restorations; failed to document in the patient records a diagnosis to justify initiating endodontic therapy in tooth #28; initiated and completed endodontic therapy in tooth #28, and while doing so, the gutta percha fill extruded out the distal of the tooth causing a communication with the oral cavity; and the Licensee failed to diagnose and document the communication in the patient records. 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 pay a \$5,000.00 civil penalty, with \$2,500.00 to be paid within 60 days of the effective date of the Order and \$2,500.00 to be paid prior to the Licensee's return to practice in Oregon; if the Licensee is practicing dentistry in Oregon, to attend at least 20 hours of Board approved hands-on diagnosis and treatment planning and operative dentistry continuing education within one year of the effective date of the Order; to submit to the Board, within one year of the effective date of the Order, documentation of successful completion of the courses required by the Consent Order, but this requirement is stayed if the Licensee leaves Oregon, but to be completed prior to the Licensee's return to practice in Oregon.

Case #2008-0129 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee, while treating a number of patients, induced central nervous system sedation without a permit; failed to document in the patient records "PARQ" or its equivalent after obtaining oral informed consent prior to providing treatment; failed to document in the patient records the name, quantity, and strength of the pretreatment medication that was taken; failed to document the amount of nitrous oxide that was administered;

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DISCIPLINARY ACTIONS (Continued from page 6)

while administering central nervous system sedation, failed to document in the patient record the patient's condition upon discharge; failed to document a diagnosis to justify extracting teeth, placing restorations, preparing teeth for crowns, and initiating endodontic treatment; and failed to document in the patient records the name, amount, and dosage of Valium that was prescribed. 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 attend at least three hours of Board approved continuing education courses in record keeping, and to pay a \$5,000.00 civil penalty.

Case #2008-0031 Aware of the Licensee's right to a hearing, and in order to resolve this matter, the Licensee voluntarily entered into an Interim Consent Order with the Board in which the Licensee agreed for six months to only practice dentistry under the supervision of a Board approved Oregon licensed dentist; to only treat patients when another licensed dentist is physically in the office; to not be solely responsible for emergent care, to have the supervising dentist review and co-sign all treatment plans, treatment notes, and prescription orders; to maintain a log of procedures done and have the supervising dentist co-sign the log; for a period of two weeks have the supervising dentist examine the appropriate stages of dental treatment to determine clinical competence; to have the supervising dentist submit ongoing written competence reports; and to complete 10 hours of Board approved continuing education within one year of the effective date of the Interim Consent Order.

Case #2007-0133 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 "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; failed to document that local anesthetic was administered; initiated endodontic therapy in a tooth without a documented dental justification; prescribed antibiotics without a documented dental justification; initiated endodontic therapy in teeth without a documented dental justification; failed to document the name of the endodontic fill

material in a tooth; and failed to document in the patient records that the patient was informed of a furcation perforation. 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 attend at least three hours of Board approved continuing education courses in record keeping.

Case #2007-0310 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist initiated endodontic therapy in the wrong tooth; initiated endodontic therapy in two teeth without any documented dental justification; failed to recognize that two teeth were perforated; and then flushed the canals of the perforated teeth with sodium hypochlorite which extruded into the surrounding bone and soft tissue. 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 attend the 40 hour Oregon Academy of General Dentistry "Update in Endodontics" continuing education participation course within one year of the date of the Order.

Case #2007-0080 and #2007-0106 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 "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment; failed to document that local anesthetic was administered; initiated endodontic therapy in a tooth without a documented dental justification; prescribed antibiotics without a documented dental justification; initiated endodontic therapy in teeth without a documented dental justification; failed to document the name of the endodontic fill material in a tooth; and failed to document in the patient records that the patient was informed of a furcation perforation. 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 attend at least three hours of Board approved continuing education courses in record keeping.

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DISCIPLINARY ACTIONS (Continued from page 7)

Case #2007-0068 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document a periodontal diagnosis; 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 document the tooth that Licensee treated; failed to document a diagnosis to justify initiating endodontic therapy; failed to document which area was examined radiographically, failed to use a facebow transfer and bite registration during the construction of five crowns and a posterior four unit bridge; seated crowns on teeth #s 6, 7, 8, 9, and 10 with faulty margins, contours and occlusion; seated a bridge on teeth #s 11, 12, and 14 with faulty margins and contours; failed to treat the patient’s TMJ dysfunction and malocclusion prior to seating eight crowns. 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 provide the Board with documentation verifying reimbursement payment of \$862.40 made to Delta Dental Insurance; to provide the Board with documentation verifying reimbursement payment of \$59.20 made to Met Life Insurance; to pay the patient \$5,507.80 in restitution; between January 2006 and January 2008, to complete 40 hours of Board approved continuing education in occlusion in addition to the hours required for licensure period April 1, 2006 to March 31, 2008; to complete three hours of Board approved continuing education in record keeping in addition to the hours of continuing education required for licensure for the licensure periods April 1, 2006 to March 31, 2008, and April 1, 2008 to March 31, 2010; within 30 days of the effective date of the Order to apply through the Oregon Academy of General Dentistry (OAGD) for entry into the Board/OAGD mentoring program, or make some other Board approved arrangement, in order to receive mentoring in the area of fixed prosthodontics; and to successfully complete and attain an acceptable level of skill in fixed prosthodontics in the Board/OAGD mentoring program, or other Board approved arrangement, at Licensee’s expense.

Case #2007-0282 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 the presence of dental caries, defective crowns and defective endodontic fills visible on radiographs; failed to document dental diagnoses prior to restoring teeth and initiating endodontic therapy; failed to document treatment that was provided and medication that was prescribed; and failed to document “PARQ” or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment. The Licensee failed to request a hearing in a timely manner so the Board issued a Default Order in which the Licensee was ordered to pay the patient a restitution amount of \$7,130.00.

Case #2008-0207 Aware of the Licensee’s right to a hearing, and in order to resolve this matter, as a result of a Final Order issued by the State of Washington Department of Health Dental Quality Assurance Commission, the Licensee voluntarily entered into an Interim Consent Order with the Board in which the Licensee agreed to not practice dentistry in the State of Oregon; and to not order, dispense, and/or prescribe any controlled drugs in the State of Oregon.

Case #2007-0123 Based on the results of an investigation the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist allowed 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 wishing to resolve these matters, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to pay a \$2,000.00 civil penalty.

Case #2007-0150 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist while treating numerous patients, failed to diagnose and document the presence of dental caries, defective crowns, and defective restorations all visible on radiographs; failed to document dental diagnoses prior to restoring teeth and initiating endodontic therapy; and failed to document in the patient records “PARQ” or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment.

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DISCIPLINARY ACTIONS (Continued from page 8)

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 attend at least 25 hours of Board approved hands-on continuing education courses in operative dentistry within one year of the effective date of the Order, and to pay a \$2,500.00 civil penalty.

Case #2008-0031 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist performed a recall exam without adequate radiographs, diagnosed Type II periodontal disease without recording periodontal probing, and did not develop a treatment plan to address the periodontal disease; failed to document an adequate medical consultation with the health care providers for a patient who is taking 19 prescription medications; failed to diagnose and document the presence of dental caries; failed to plan for the restorations of carious crown margins; and failed to diagnose cariously involved non-restorable teeth, all conditions that were evident on radiographs; when placing a restoration, allowed a patient to insist on the placement of the restoration without the removal of caries; failed to document some diagnostic tests used to determine the source of a patient's swelling; failed on several occasions to diagnose and document caries that was evident in radiographs; failed to develop a treatment plan for treatment of a patient's periodontal disease; diagnosed caries in a patient but failed to develop and document a treatment plan or refer the patient for treatment; diagnosed the need for extracting a tooth without giving the patient the option of endodontic therapy; and seated a crown with a defective margin. 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, to attend at least three hours of Board approved continuing education courses in record keeping and at least seven hours of Board approved continuing education in treating caries and periodontal disease as infections within one year of the effective date of the Order, to practice dentistry in a group practice under the supervision of a Board approved Oregon licensed dentist for a period of two years from the effective date of the Order,

and Paragraphs 1 and 2 of the Interim Consent Order in this matter are modified to change all references to "six months" to read "one year."

Case #2005-0022 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee failed to diagnose and document a radiolucent bone lesion distal to tooth #18 that was visible on radiographs taken on November 18, 2002 and January 19, 2004. 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 #20087-0092 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 "PARQ" or its equivalent after the Licensee had obtained oral informed consent prior to providing treatment, prepared teeth for crowns without any documented dental justification, prescribed controlled substances and antibiotics without any documented dental justification, initiated endodontic therapy without any documented dental justification, failed to document a short endodontic fill, provided periodontal therapy without any documented dental justification, extracted a tooth without any documented dental justification, did an occlusal adjustment without any documented dental justification, prepared a tooth for a crown without any documented dental justification, and seated a crown but failed to document the treatment in the patient's records. 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 complete at least three hours of a Board approved continuing education course in record keeping within six months of the effective date of the Order.

Case# 2006-0225 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee failed to document in the patient records that the Licensee placed glass ionomer bases under the restorations the Licensee placed in teeth #s 12, 14, 15, and 19, and placed a composite

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DISCIPLINARY ACTIONS (Continued from page 9)

restoration in tooth #12 – DO that intruded into the pulp chamber of the tooth; and from April 1, 2003 to March 30, 2005, the Licensee failed to complete the four hours of continuing education as required during the license renewal period for maintenance of the Licensee’s Class 1 Anesthesia Permit. 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 provide 40 hours of Board approved community service within 18 months of the effective date of the Order, and the Licensee shall not administer nitrous oxide until the Licensee has completed the continuing education requirements for maintenance of the Licensee’s Class 1 Anesthesia Permit.

Case #2005-0028 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee failed to document in the patient records “PARQ” or its equivalent after the Licensee had obtained informed consent prior to providing treatment and failed to diagnose and document periodontal disease that was visible on radiographs taken on May 2, 2000 and also evident on periodontal probings done on May 2, 2000. 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 #2008-0004 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee failed to document in the patient records “PARQ” or its equivalent after the Licensee had obtained informed consent prior to providing treatment, prepared teeth for crowns without any documented dental justification, prepared teeth that were periodontally compromised with severe bone loss for crowns, and extracted five teeth while taking impressions for crowns and then replaced the teeth in their sockets without addressing the pulpal health of those 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 agreed to be reprimanded and pay a \$500.00 civil penalty.

Case #2008-0002 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee failed to document the taking of four panoramic radiographs, did not consult with the patient’s physician when warranted, did not document the findings of a periodontal examination, did not document the examination of the patient nor the development of a treatment plan, did not document the taking of impressions and bite registration, placed eight implants without the use of a drill guide, did not document “PARQ” or its equivalent prior to treatment, and removed tissue without a diagnosis to justify the 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 be reprimanded and to attend at least 28 hours of Board approved continuing education in implant placement and osseointegration and at least three hours of Board approved continuing education in record keeping to be completed within one year of the effective date of the Order.

Case #2007-0010, #2007-0044, and #2007-0075 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee fabricated full upper and partial lower dentures that did not meet the minimum acceptable standards of construction for three 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, to pay a total of \$2000.00 in restitution to the three patients, and to attend at least 40 hours of Board approved continuing education in complete removable prosthodontics within 180 days of the effective date of the Order.

Case #2008-0224 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that the Licensee wrote a prescription for two tablets of Valium 10mg, but documented in the patient records that the Licensee had prescribed two tablets of Valium 5mg; wrote a prescription for two tablets of Valium 10mg, when the Licensee should have prescribed two tablets of Valium 5mg; wrote a prescription for two tablets of

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DISCIPLINARY ACTIONS (Continued from page 10)

Valium 10mg, which the patient subsequently took two hours prior to the appointment on March 12, 2008, thus providing to the patient a level of sedation the Licensee did not have a permit to provide. 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.

Practicing Dentistry Without a License ORS 679.020

Case #2007-0286 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that between April 2, 2007 and April 30, 2007, a dentist practiced dentistry without a license on April 24, 2007 and 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. 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, to provide 80 hours of Board approved community service within one year of the effective date of the Order, to complete the 40 hours of Board approved continuing education for the licensing period that ended March 31, 2007 within six months of the effective date of the Order, and to pay a \$5,000.00 civil penalty.

Case #2008-0164 Based on the results of an investigation, the Board alleged that an unlicensed person engaged in the practice of dentistry during January and February 2008 and during that time period provided dental surgery to a patient that resulted in a life-threatening infection that required hospitalization. Aware of the right to a hearing, and in order to resolve this matter, the person voluntarily entered into a Temporary Stipulated Order with the Board in which the person agreed to not practice dentistry in any way, to keep the Board aware of the person's current telephone number and address, to not refer to the person as a dentist nor advertise claiming to be a dentist.

Practicing Dental Hygiene Without a License ORS 680.020

Case #2008-0070 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that between October 1, 2007 and October 3, 2007, a dental hygienist practiced dental hygiene without a license. 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 pay a \$500.00 civil penalty.

Case #2008-0123 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist failed to complete the 24 hours of continuing education required for the October 1, 2005 and September 30, 2007 licensing period; on September 17, 2007 made an untrue statement on the Licensee's application for renewal of the Licensee's license to practice dental hygiene in Oregon when the Licensee declared and signed the application certifying that the Licensee had completed the required continuing education hours between October 1, 2005 and September 30, 2007; and between October 1, 2007 and November 28, 2007, practiced dental hygiene without a license. 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 pay a \$500.00 civil penalty.

Case #2008-0079 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that between October 1, 2007 and October 4, 2007, a dental hygienist practiced dental hygiene without a license. 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, to pay a \$500.00 civil penalty, and to provide five hours of Board approved community service within six months of the effective date of the Order.

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 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

2009

- January 30, 2009
- March 20, 2009
- May 15, 2009
- July 24, 2009
- September 25, 2009
- November 20, 2009

DISCIPLINARY ACTIONS (Continued from page 11)

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

Case #2008-0022 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 25, 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 between March 31, 2007 and September 7, 2007 failed to respond to the Board's written request for information within 10 days of the Board's demand. 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 #2008-0067 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to complete the four hours of continuing education required for renewal of the Licensee's Class 1 nitrous oxide permit and 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, 2004 through March 31, 2006. 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 \$2,500.00 civil penalty.

Case #2008-0024 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 2004-2006 license renewal period and on March 27, 2006 made an

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DISCIPLINARY ACTIONS (Continued from page 12)

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, 2004 through March 31, 2006. 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 \$1,000.00 civil penalty, to provide 10 hours of Board approved community service, and to complete the 40 hours of Board approved continuing education for the licensing period that ended March 31, 2006 within six months of the effective date of the Order.

Case #2008-0156 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 and on February 22, 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. 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 \$1,000.00 civil penalty, to provide 10 hours of Board approved community service, and to complete the 40 hours of Board approved continuing education for the licensing period that ended March 31, 2007 within six months of the effective date of the Order.

Unprofessional Conduct ORS 679.140(2)(c)

Case #2007-0071 Based on the results of an investigation, alleged that a dental hygienist was addicted to, dependent upon, or abused alcohol; failed to respond to a written request by the Board for information; and chose to not take the necessary steps to enter the Board's Voluntary Diversion program. 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 have the Licensee's license be placed on probation for at least five years; to not use alcohol, controlled drugs, or mood altering drug substances; to undergo an evaluation by a Board approved addictionologist or treatment center within 30 days of the Order; to adhere to, participate in, and complete all aspects of any program or treatment plan recommended; to waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment; to submit to a Board approved urinalysis testing program; and to appear before the Board at a frequency determined by the Board.

Applicant Issues ORS 679.060(4)

Case #2008-0077 Based on the results of an investigation into the information provided in an application for a license to practice dental hygiene through the Licensure Without Further Exam pathway in which the Applicant provided falsified documents, the Board determined that legal cause existed to deny the Applicant's application for licensure and issued a Notice of Proposed Denial of Application for License. The Applicant failed to request a hearing in a timely manner so the Board issued a Default Order in which the license application of the Applicant was denied.

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

Case #2006-0104 On January 4, 2008, by a Consent Order, the dentist agreed to pay a \$2,500.00 civil penalty within 60 days of the effective date of the Order. The Licensee, then retired the Licensee's dental license, but subsequently failed to pay the \$2,500.00 civil penalty within the 60 days, and then failed to respond to the Board's written request for an explanation within 10 days. 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 license retirement was rescinded, the ordered provisions of the January 4, 2008 Consent Order were vacated, the Licensee agreed to be reprimanded, to surrender Oregon dental license D8199, to never reapply for an Oregon dental license and never apply for reinstatement of Oregon dental license D8199. ■

STIMULATING CONVERSATION???

by Jill Mason, M.P.H, R.D.H.

1. To attempt to generate a conversation about a topic (verb)

2. Describes a conversation that results in a heightened knowledge or thoughtfulness about a topic (adjective)

No matter how you interpret the word “stimulating” in this phrase, it represents that there can be two ways to interpret the phrase. An article in the last newsletter from the Board of Dentistry stimulated much conversation about a topic, just as it was intended to do. It also generated multiple interpretations of the article.

The Board of Dentistry uses its newsletter to inform licensees of current happenings, changes in the Dental Practice Act, and other topics that may be helpful to licensees in their practice and interactions with the Board. The last newsletter featured a guest article by Dr. Gary Chiodo, regarding what might be considered appropriate conversation topics in a professional role.

Three things led to the inclusion of that article in the newsletter. 1) The American Association of Dental Examiners included that topic as a national topic of interest at their meeting, meaning there are many states dealing with this issue, 2) The State of Oregon was, at that time, revising the administrative rules as to what constitutes appropriate and ethical behavior and boundaries for health professionals, and 3) The Board had reviewed recent cases that had indicated that maybe it was time for a reminder for licensees to think about what a patient might consider inappropriate. After all, in these situations, it is truly in the eye of the beholder.

Dr. Gary Chiodo, a nationally known expert in ethics, and an Oregon dentist with a working knowledge of practice, was asked to provide an article discussing the topic. The Board’s purpose for publishing the article was to stimulate thought and discussion about boundaries and appropriate conversations between providers and patients. That goal was clearly met. The feedback we have received on the article indicates that the target audience was clearly reached and definitely stimulated.

The Board has learned a few things in this process.

1) Licensees really DO read the newsletter, thus making it a successful forum for us to communicate with licensees. 2) Any articles in the newsletter in the future should have specific clarification as to whether it is an opinion or an official policy of the Board. It is not sufficient to indicate the author’s name and affiliation (In this case, he was obviously not affiliated with nor a member of the Board.) 3) The length of time between newsletters makes it appear to some that we are “refusing” to state it was an opinion and not Board policy. That is not the case at all. It was an inadvertent oversight that we were not more specific about Dr. Chiodo’s opinion piece not being Board policy. We will make every effort to specify in the future.

Are there any licensees who would be interested in submitting an article to stimulate discussion? ■

FAREWELL TO BOARD MEMBER

We wish to extend a great big “Thank you” to Dr. Ronald Short of Klamath Falls for his eight plus years of dedicated service to the Board of Dentistry and the citizens of Oregon. Dr. Short served in many different roles including President of the Board, Board Liaison to the American Association of Dental Examiners, and a member of the Board of Directors of the Western Regional Examining Board.

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

Dr. Short will be missed by his fellow Board members and staff and we wish him well in his future endeavors. ■

IMPAIRED LICENSEES

The Oregon Board of Dentistry has a confidential Voluntary Diversion Program to address the needs of Licensees who struggle with substance abuse matters. This program permits a Licensee to be in recovery and continue to practice without discipline by the Board.

If you have questions about the program, or concerns about a Licensee, call –

Investigator Harvey Wayson
(971) 673-3200
7:00 a.m. — 3:00 p.m.

NEW BOARD MEMBER

Jonna E. Hongo, D.M.D., of Portland, joined the Board in August of 2008 as a dental member. Dr. Hongo has a B.S. degree in Zoology from Idaho State University and received her D.M.D. degree from OHSU.

She has been practicing dentistry in Oregon for 26 years and is a member of the American Dental Association, Oregon Dental Association and the Multnomah County Dental Society.

She and her husband Gary S. Hongo, D.M.D., have two children and she enjoys volunteering, reading and music. ■

FIRST DAY ON THE JOB

by Jonna E. Hongo, D.M.D.



Having accomplished my maiden voyage in the most junior member chair position at the Oregon Board of Dentistry, I am impressed with the efficiency and humility of this body. The entire staff, all the members of the Board, and even Dan the parking lot attendant, made every effort to make me feel welcome. There is an honor in accepting this appointment, but hard work is expected. Protecting the public, sifting the sublime with reality, and generating justice are the goals of our deliberations. After trying to digest the high points of the 4.5 pound Handbook, meeting all the friendly staff, and getting a crash course in computer technology, I sat down to speed read over 450 pages of written material in preparation for the first meeting. As in any business meeting, there are minutes and reports and introduction of guests on the agenda, but the section that piques the most interest are the case presentations of dental situations that are to be interpreted and adjudicated for dispensation of fairness.

The rules by which we play are, of course, the Dental Practice Act (ORS Chapter 679 and 680) and the Oregon Administrative Rules for the Board (OAR Chapter 818). Mind you, the detailed case presentations have been thoroughly reviewed and

analyzed by one of our dedicated investigators; re-reviewed and re-analyzed by a team of Board member Evaluators; and then presented to the entire Board to be reviewed and analyzed a third time before action is taken. Every effort is exhausted to outline the facts, nuances and human elements that define these dental quandaries. In effect, this is not a “quick and dirty – get it done” organization. Careful consideration is given to all parties involved, including the final arbitrators.

As I penned my signature on 180 displayable parchments for the newest licensees of dentistry and dental hygiene in Oregon, I reflected upon the proceedings of the Board meeting. If there was one particular word of advice I could give to each of these new, eager practitioners it would be “records.” Dentists and hygienists pride themselves on their meticulous attention to detail. I would certainly hope this would extend into the written word that is the art and science of the business of dentistry. A wise practitioner once told me, “If it’s not written down, it never happened.” Admittedly, some people are more verbose than others, but there are bare essentials that are required to meet the standards of practice. And certainly there are acronyms and generally recognized abbreviations that fulfill these standards. Probably the most recognizable of which is PARQ and SOAP. The Board’s OAR 818-012-0010(10) requires that licensees obtain a patient’s or guardian’s informed consent prior to performing any procedure. The Board’s OAR 818-012-0070(c) requires when informed consent has been obtained, licensees document such and the date the consent was obtained. This documentation may be in the form of an acronym such as PARQ (Procedure, Alternatives, Risks and Questions) or SOAP (Subjective, Objective, Assessment and Plan). I recognize that all the new graduates from OHSU School of Dentistry must have the PARQ mantra. I also realize that anyone who has attended a risk management course in the last eight years must have the same mantra. The importance of this four letter abbreviation has been pounded into our consciousness. Yet I found it extremely interesting that this basic bit of information was lacking in many of the dental cases I reviewed. My hope is that the new licensees reading these words will take them to heart.

As I begin this journey of service for the public, I am aware of the opportunity not only to serve but to learn and hopefully be an approachable advocate for our profession. ■

OREGON BOARD OF DENTISTRY

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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