

IN THE MATTER OF	*	BEFORE THE MARYLAND
CUNPING QIU, D.M.D.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 14572	*	Case Numbers: 2017-065 & 132

* * * * *

CONSENT ORDER

On or about July 17, 2019, the Maryland State Board of Dental Examiners (the “Board”) charged **CUNPING QIU, D.M.D.** (the “Respondent”), license number 14572, under the Maryland Dentistry Act, codified at Md. Code Ann., Health Occ. (“Health Occ.”) §§ 4-101 *et seq.* (2014 Repl. Vol. & 2018 Supp.) (the “Act”) and the regulations adopted by the Board at Md. Code Regs. (“COMAR”) 10.44.01 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of law:

Health Occ. § 4-315 Denials, reprimands, probations, suspensions, and revocations – Grounds.

- (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may ... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
 - (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
 - (11) Permits an unauthorized individual to practice dentistry under the supervision of the applicant or licensee;

- (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
- (19) Provides a dental service in a manner that is significantly inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs;
- (18) Demonstrates a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs;
- (20) Violates any rule or regulation adopted by the Board;

COMAR 10.44.19.01 Definitions.

B. Terms Defined.

- (2) "Dental radiation technologist" means an individual other than a licensed dentist or a licensed dental hygienist who practices dental radiation technology.
- (6) "Practice of dental radiation technology" means the placement or exposure of dental radiographs by an individual other than a licensed dentist, a licensed dental hygienist, an individual permitted to practice dentistry without a license under Health Occupations Article, §4-301(b)(1), (2), or (3), Annotated Code of Maryland, or an individual enrolled in an educational program recognized by the Board for dental hygiene or dental assisting, who places or exposes dental radiographs pursuant to the educational program.

COMAR 10.44.19.02 Certification Required.

An individual shall be currently certified by the Board as a dental radiation technologist before the individual may practice dental radiation technology on a human being in this State.

COMAR 10.44.19.12 Penalties for Violations of These Regulations.

- C. A licensed dentist who employs an individual to practice dental radiation technology who is not certified under these regulations is guilty of

unprofessional conduct and may be subject to disciplinary action under Health Occupations Article, § 4-315, Annotated Code of Maryland.

- D. A licensed dentist who supervises an individual practicing dental radiation technology who is not certified under these regulations is guilty of permitting an unauthorized individual to practice dentistry under the supervision of that licensed dentist, and may be subject to disciplinary action under Health Occupations Article, § 4-315, Annotated Code of Maryland.

COMAR 10.44.23.03 Unprofessional or Dishonorable Conduct.

- A. A dentist, dental hygienist, or dental radiation technologist may not engage in unprofessional or dishonorable conduct.
- B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry, dental hygiene, or dental radiation technology:
 - (4) Permitting or failing to prevent the placement or exposure of dental radiographs by an individual not certified or otherwise qualified to do so;

COMAR 10.44.30.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

- K. Dental records shall:
 - (1) Be accurate;
 - (2) Be detailed;

COMAR 10.44.30.03 Clinical Charts.

- A. Each patient's clinical chart shall include at a minimum the following:
 - (5) Diagnosis and treatment notes;
 - (12) Radiographs of diagnostic quality;
 - (15) Informed consent;

COMAR 10.44.30.05 Violations.

Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On or about September 18, 2019, following a Case Resolution Conference held at the Board's offices, the Respondent and the Board agreed to enter into this Consent Order.

FINDINGS OF FACT

The Board finds the following facts.

- 1) At all times relevant hereto, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed on June 27, 2010. His license is current through June 30, 2020.
- 2) At all times relevant hereto, the Respondent has practiced dentistry at a private practice located at 5711 Sarvis Ave, Suite 600, Riverdale, Maryland 20737 (the "Office").

Investigation – Case Number 2017-065

- 3) On or about October 28, 2016, the Board received a complaint ("Complaint 1") from the spouse of one of the Respondent's patients ("Patient 1") alleging that the Respondent had improperly treated Patient 1. Specifically, Complaint 1 alleged that the Respondent broke Patient 1's tooth while performing root canal treatment (RCT) and improperly re-seated a bridge with the broken tooth as one of the supports.
- 4) Based on Complaint 1, the Board initiated an investigation under case number 2017-065.

- 5) In furtherance of the investigation, the Board obtained the Respondent's patient records for Patient 1, along with a narrative summary of care by the Respondent, and Patient 1's records from two subsequent treatment providers.
- 6) In addition, the Board obtained the Respondent's patient records, along with narrative summaries of care by the Respondent for five additional patients of the Respondent ("Patients A, B, C, D & E").
- 7) After a review, it was determined that the patient records received from the Respondent, submitted in response to Board subpoenas for complete patient records, were incomplete. Specifically, a number of radiographs and treatment notes were missing.
- 8) On or about October 30, 2018, the Board notified the Respondent that he was required by the original subpoena to produce the missing records, and requested the missing documents.
- 9) On or about November 13, 2018, the Respondent responded and submitted additional radiographs responsive to the Board's subpoena.
- 10) In furtherance of the investigation, the Board referred the patient records and all relevant materials to a Maryland-licensed dentist who is board-certified in endodontics (the "Expert") for a review of the Respondent's care.
- 11) On or about December 22, 2018, the Board received a report of the Expert's findings. The Expert opined that the endodontic treatment rendered by the Respondent, "showed a pattern of violation of the standard of care and gross incompetence." Additionally, the Expert concluded that the Respondent's recordkeeping was inadequate.
- 12) In summary, the Expert found that:

- a) In 4 of the 6 patients, the treatment rendered by the Respondent demonstrated gross incompetence;
 - b) In 5 of the 6 patients, the treatment rendered by the Respondent demonstrated that the Respondent failed to meet professional standards of care; and
 - c) In 5 of the 6 patients, the Respondent's recordkeeping was inadequate.
- 13) Specifically, the Expert found in her report the following patient-specific deficiencies.

Patient 1

14) Patient 1 began seeing the Respondent for treatment, starting in or around October 2015. On or about March 8, 2016, the Respondent attempted to perform RCT on Patient 1's tooth #9. However, the canal was calcified and the root was perforated (i.e. an unintentional opening was made through the side of the root). The Respondent therefore recommended apicoectomy, i.e. removal of the root tip, or apex, along with infected tissue, and a filling placed to seal the end of the root.

15) On or about March 16, 2016, the Patient returned for apicoectomy and retrograde (root end) amalgam filling on tooth #9. No informed consent was noted in the record for this procedure. On the same visit, an odontogenic cyst at the root end (1.0 cm x 1.0 cm) was removed by the Respondent. The Respondent did not order a biopsy on the cyst.

16) On or about May 7, 2016, the Respondent billed for a permanent restoration on tooth #9. However, there was no treatment record of a restoration on this date.

17) After complaining of a bad taste in his mouth, continued pain, and draining of the tooth, the Patient subsequently sought out another provider, who recommended removal of tooth #9.

18) According to the Expert, the Respondent's treatment demonstrated gross incompetence for the following reasons:

- a) Failure to use a dental (rubber) dam during the attempted RCT on March 8, 2016; and
- b) Failure to repair the perforation the Respondent caused when he attempted RCT on March 8, 2016.

19) According to the Expert, the Respondent's treatment was inconsistent with generally accepted professional standards of care for the following reasons:

- a) Failure to use a dental (rubber) dam during the attempted RCT on March 8, 2016;
- b) Failure to repair the perforation the Respondent caused when he attempted RCT on March 8, 2016;
- c) Failure to refer Patient 1 to a specialist given the high level of difficulty associated with performing RCT on a tooth with a calcified canal. The Respondent further failed to refer to a specialist even after his attempt at RCT resulted in complications. In fact, the Respondent was aware of the difficulty of the case, writing in his notes: "Patient was informed that this root canal was very challenging and I preferred to refer him to the endodontist. Patient insisted to have this root canal done in our practice without referring out. I agreed to have a try.";
- d) Failure to employ any disinfection of the canal space;
- e) Failure to perform or document a permanent restoration in order to prevent coronal leakage; and
- f) Failure to document or perform removal of the separated instrument that occurred during the attempted RCT.

20) According to the Expert, the Respondent's recordkeeping was inadequate for the following reasons:

- a) Failure to document proper informed consent;
- b) Failure to mention in the treatment notes the separated instrument apparent on radiograph from March 8, 2016;

- c) Treatment notes lack detail; and
- d) No treatment notes documenting a restoration that was billed as performed on May 7, 2016.

Patient A

21) On or about June 15, 2015 the Respondent saw Patient A and extracted teeth #1 and #16. On or about July 14, 2015, the Respondent extracted tooth #17. On or about August 18, 2015, the Respondent extracted tooth #32, which was “partial bony impacted.”

22) According to the Expert, the Respondent’s treatment was inconsistent with generally accepted professional standards of care for the following reasons:

- a) Failure to refer Patient A to a specialist/oral surgeon given the high level of difficulty associated with extracting impacted or partially impacted third molars;
- b) Failure to document or obtain informed consent in the record for the extractions performed on teeth #1 and #16; and
- c) Failure to obtain recent panoramic radiographic evaluation, which is necessary prior to third molar extractions in order to visualize the entire tooth, and the surrounding anatomical structures.

23) According to the Expert, the Respondent’s recordkeeping was inadequate for the following reasons:

- a) Failure to document proper informed consent for extraction of teeth #1 and 16; and
- b) Treatment notes lack detail, *e.g.* on August 18, 2015, the Respondent noted that Patient A was “sick” without elaboration.

Patient B

24) Patient B saw the Respondent for treatment from April 2015 until June 2016, beginning on April 14, 2015 with a complaint of tooth sensitivity.

25) The Respondent's treatment included RCT on tooth #20 on June 29, 2015. Tooth #20 had previously had RCT, so the Respondent's treatment on this day included removal of the previous root canal filling material.

26) The day after RCT, Patient B returned for apicoectomy based on a fracture and a lesion discovered the previous day. No permanent restoration appears to have been performed.

27) On or about July 27, 2015, Patient B returned and the Respondent planned RCT on tooth #19 due to pain on percussion, and later discovered pulp exposure. However, there is no indication that the Respondent ever actually performed the RCT on tooth #19.

28) According to the Expert, the Respondent's treatment demonstrated gross incompetence for the following reasons during the attempted RCT on June 29, 2015:

a) Failure to use a dental (rubber) dam.

29) According to the Expert, the Respondent's treatment was inconsistent with generally accepted professional standards of care for the following reasons during the attempted RCT on June 29, 2015:

a) Failure to use a dental (rubber) dam;

b) Failure to consider referring Patient B to a specialist given the high level of difficulty associated with performing RCT and surgery on tooth #20, which had previously had RCT;

c) Failure to employ any disinfection of the canal space;

d) Failure to perform or document a permanent restoration in order to prevent coronal leakage; and

e) There is no mention or radiographic evidence of a retrofill to seal the canal apically (at the end of the root).

30) According to the Expert, the Respondent's recordkeeping was inadequate for the following reasons:

- a) Failure to document proper informed consent for any treatment performed.

Patient C

31) Patient C received treatment from the Respondent from December 2015 to August 2016. Patient C initially presented to the Respondent on December 10, 2015 with a complaint of bleeding gums, loose teeth or broken fillings, and sensitivity.

32) On or about January 4, 2016, the Respondent performed RCT on tooth #15.

33) On or about January 27, 2016, the Respondent performed RCT on tooth #14.

34) According to the Expert, the Respondent's treatment demonstrated gross incompetence for the following reasons during the RCTs on January 4 & 27, 2016:

- a) Failure to use a dental (rubber) dam.

35) According to the Expert, the Respondent's treatment was inconsistent with generally accepted professional standards of care for the following reasons during the RCTs on January 4 & 27, 2016:

- a) Failure to use a dental (rubber) dam; and
- b) Failure to employ any disinfection of the canal space, only saline.

36) According to the Expert, the Respondent's recordkeeping was inadequate for the following reasons:

- a) Failure to document proper informed consent for any treatment performed.

Patient D

37) Patient D did not receive endodontic (RCT) treatment from the Respondent, and the Expert did not find deficiencies in the Respondent's non-RCT treatment of Patient D.

Patient E

38) Patient E began treatment with the Respondent when she presented on November 11, 2014, for examination and prophylaxis.

39) On or about July 1, 2015, the Respondent performed RCT on tooth #10. Subsequently, the Respondent extracted teeth #9 & #11.

40) According to the Expert, the Respondent's treatment demonstrated gross incompetence for the following reasons during the RCT on July 1, 2015:

a) Failure to use a dental (rubber) dam.

41) According to the Expert, the Respondent's treatment was inconsistent with generally accepted professional standards of care for the following reasons during the RCT on July 1, 2015:

a) Failure to use a dental (rubber) dam; and

b) Failure to employ any disinfection of the canal space, only saline.

42) According to the Expert, the Respondent's recordkeeping was inadequate for the following reasons:

a) Failure to document proper informed consent for the extractions of teeth #9 and #11.

Investigation – Case Number 2017-132

43) On or about February 3, 2017, the Board received a second complaint ("Complaint 2") from a former employee alleging that the Respondent was violating the Act.

Complaint 2 included the allegation that the Respondent was employing and supervising an unauthorized individual practicing dental radiation technology at the Office.

44) Based on Complaint 2, the Board initiated an investigation under case number 2017-132.

45) In furtherance of the investigation, on approximately February 2017, a Board-assigned inspector conducted an inspection of the Office, which covered, in part, whether the Office was in compliance with certain OSHA rules.¹ The Board-assigned inspector prepared a report of her inspection, in which she stated that during the inspection, it appeared that an unidentified dental assistant employed at the Office may have been placing XCP for patients.²

46) On or about March 29, 2017, in furtherance of the investigation and with the aim of identifying the unnamed dental assistant, a Board investigator obtained an employee listing from the Respondent.

47) On or about October 19, 2017, the investigator contacted an employee who worked as a hygienist at the Office from approximately January 2016 to early 2017 (“Employee A”). Employee A stated that a dental assistant (“Employee B”) took most of the x-rays during the time she was employed at the Office. Employee B has never held a certificate to practice dental radiation technology from the Board.

48) On or about October 24, 2017, Board investigators conducted a sworn interview with a licensed dentist employed by the Respondent (“Employee C”). Employee C stated that she

¹ OSHA refers to the Federal Occupational Health and Safety Administration.

² XCP refers to “extension cone paralleling,” a device that holds radiographic film and is inserted into a patient’s mouth immediately before exposure.

currently worked at the Office approximately two days per week and had been doing so for the past year.

49) Employee C also stated under oath that on approximately three occasions, she had personally observed Employee B placing XCP in patient's mouths and lining up the x-ray machine immediately before the Respondent exposed the radiographs by pushing the machine's button.

50) On or about December 14, 2017, Board investigators conducted a sworn interview with Employee B. During the interview, Employee B stated that in early 2017, she completed a course in radiation technology at University of Maryland but had never taken the certification exam.

51) Employee B also stated that in early 2017, she did expose radiographs at the Office. She also stated that she admitted doing so to "some people who came here from the OSHA Department." (Employee B was likely referring to the February 2017 inspection by the Board-assigned inspector).

52) Employee B stated that after the inspection, she stopped exposing radiographs herself and currently only assists the Respondent to do so: "I just prepare. I get -- what is it? The camera, the XP, and then prepare for him [the Respondent]. And then when he -- when the -- to take the X-ray is ready, he push the button."

53) Employee B stated that the Respondent is currently aware that she is not certified as a dental radiation technologist.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Board concludes the following as a matter of law.

Case Number 2017-065

The Respondent's conduct as described above constitutes: practicing dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of Health Occ. § 4-315(a)(6); behaving dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); providing a dental service in a manner that is significantly inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs, in violation of Health Occ. § 4-315(a)(19); demonstrating a course of conduct of providing dental care that is inconsistent with generally accepted professional standards of care in the practice of dentistry, regardless of whether actual injury to the patient occurs, in violation of Health Occ. § 4-315(a)(18); violating any rule or regulation adopted by the Board, in violation of Health Occ. § 4-315(a)(20), specifically: COMAR 10.44.30.02 & 10.44.30.03.

Case Number 2017-132

The Respondent's conduct as described above, including employing and supervising Employee B, who was practicing dental radiation technology while not certified by the Board, constitutes permitting an unauthorized individual to practice dentistry under the supervision of the applicant or licensee, in violation of Health Occ. § 4-315(a)(11); behaving dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the

dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violating any rule or regulation adopted by the Board, in violation of Health Occ. § 4-315(a)(20), specifically: COMAR 10.44.19.12 & 10.44.23.03.

ORDER

Based on the foregoing findings of fact and conclusions of law, it is, by a majority of a quorum of the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS** under the following terms and conditions:

1. Within two (2) years of the effective date of the consent order, the Respondent shall pay a monetary penalty in the amount of **two thousand five hundred dollars (\$2500.00)** to the Board;
2. Within six (6) months of the effective date of the consent order, the Respondent shall, at his own expense, successfully complete an **in-person one-on-one course, approved by the Board in advance, equivalent to at least six (6) continuing education (C.E.) credits**, focusing on endodontic treatment; and the Respondent shall submit written verification that satisfies the Board of the successful completion of the course within 30 (thirty) days of completion of the course;
3. Within six (6) months of the effective date of the consent order, the Respondent shall, at his own expense, successfully complete an **in-person course, approved by the Board in advance, equivalent to at least four (4) continuing education (C.E.) credits**, focusing on dental recordkeeping; and the Respondent shall submit written verification that satisfies the Board of the successful completion of the course within 30 (thirty) days of completion of the course;
4. At its discretion, the Board may conduct up to three (3) record reviews of the Respondent's records. Each record review shall be conducted by a Board-designated expert, who shall review the records of a selection of patients whom the Respondent treated after completing the courses mentioned above. The Board designee shall personally select the records on site at the Respondent's practice, and may do so

at either a scheduled or unannounced visit. An unsatisfactory review, as determined in the sole discretion of the Board, shall constitute a violation of the Consent Order;

5. In order to facilitate the record reviews described above, the Respondent shall, on the first day of each month, provide the Board with a copy of his appointment book. The Respondent shall notify the Board beforehand of any changes to his schedule that will result in his absence from the office, unless he is unable to do so by reason of documented emergency or illness; and
6. The Respondent shall comply with the Maryland Dentistry Act;

And it is further

ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the Board-assigned inspector, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of two (2) years from the effective date of the Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all probationary terms and conditions


and there are no pending investigations or outstanding complaints related to the findings of fact in this Consent Order; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be an evidentiary hearing before the Board. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board; and it is further

ORDERED that after the appropriate hearing, if the Board determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice dentistry in Maryland. The Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent;

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

October 16, 2019
Date



Francis X. McLaughlin, Jr.
Executive Director
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Cunping Qiu, D.M.D., agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having consulted with counsel, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order and understand its effect.

Oct. 1st, 2019
Date

Cunping Qiu
Cunping Qiu, D.M.D.
The Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 1st day of October 2019,
before me, a Notary Public of the State and County aforesaid, personally appeared Cunping
Qiu, D.M.D., and gave oath in due form of law that the foregoing Consent Order was his
voluntary act and deed.

AS WITNESS, my hand and Notary Seal.



Notary Public

A handwritten signature in blue ink that reads "Stephanie Hase".

My commission expires: December 1, 2019