IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GERRY DUBIN, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 8457	*	**Case Number: 2014-210**

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ORDER FOR SUMMARY SUSPENSION

The Maryland State Board of Dental Examiners (the "Board") hereby **SUMMARILY SUSPENDS** the license of **GERRY DUBIN, D.D.S.** (the "Respondent"), License Number 8457, to practice dentistry in the State of Maryland. The Board takes such action pursuant to its authority under Md. Code Ann., State Gov't ("S.G.") § 10-226(c)(2) (2009 Repl. Vol. and 2012 Supp.), concluding that the public health, safety, or welfare imperatively requires emergency action.

The Board bases its action on the provisions of The Maryland Dentistry Act (the "Act"), codified at Md. Code Ann., Health Occ. ('H.O.") §§ 4-101 et seq. (2009 Repl. Vol & 2013 Supp.). The pertinent provision of the Act, H.O. § 4-315(a), provides:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
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> . . .
>
> (28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's ["CDC"] guidelines on universal precautions...

The pertinent regulations under Code Regs. Md. ("COMAR") § 10.44.23.01 include:

A. A dentist...may not engage in unprofessional or dishonorable conduct.

B. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry...:

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry...

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by, and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

1. At all times relevant to this Order, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about August 8, 1983, under license number 8457. In addition, the Respondent obtained a license in the District of Columbia by endorsement on or about May 18, 2012, under license number DEN1001114.

2. At all times relevant to this Order, the Respondent operated a general dental practice in Gaithersburg, Maryland (the "Gaithersburg Office").

3. On or about April 10, 2014, the Board received a complaint (the "Complaint") from a Certified Dental Assistant (the "Complainant") expressing concern about the state of the Respondent's office, specifically, that she had observed unsanitary conditions.

4. On or about April 21, 2014, based on a review of the Complaint, the Board assigned a Board Expert (the "Expert") to conduct an unannounced inspection of the Respondent's Gaithersburg office.

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

5. On or about April 23, 2014, the Expert conducted an unannounced CDC inspection of the Gaithersburg Office to determine whether the Respondent was in compliance with the Act and the Centers for Disease Control ("CDC")[2] guidelines on universal precautions.

6. During on the inspection, the Expert found widespread CDC violations. The violations were of such significance that the Expert concluded that it was "unsafe for patients to undergo dental treatment" at the Gaithersburg Office.

7. A summary of these findings is set forth *infra*.

Office inspection, dated April 23, 2014

8. At the time the Expert's inspection, the Expert was able observe the Respondent provide dental treatment to several patients and inspect the Office. The Respondent reportedly does not employ any dental hygienists, assistants or other personnel to assist him in his practice.

9. The Expert noted that the Respondent's office consists of a reception area, a receptionist's desk, five dental operatories, and a room used as a laboratory/sterilization/radiology/darkroom.

10. The Expert completed a report, accompanied by photographs, dated April 23, 2014, in which he called the lack of cleanliness "astounding." He found that "Dr. Dubin seems to have a flagrant disregard for cleanliness and the importance of infection control."

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[2] The CDC is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one's hands prior to and after treating a patient, and also set forth more involved standards for infection control. Under the Act, all dentists are required to comply with the CDC guidelines which incorporate by reference Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

11. In addition, the Expert found that, "the lack of fundamental infection control compliance . . . places the patients treated in this office at risk for acquiring [an] infections disease."

12. The Expert's findings regarding the condition of the Office included but were not limited to the following:

(a) The laboratory/sterilization/radiology/darkroom was "filthy with every surface inclusive of the floor covered with dirt and debris";

(b) The autoclave was "covered with a layer of dust and dirt";

(c) In the operatories, "almost every clinical contact" including light handles, 3-way syringes, radiology heads, instrument trays, drawers, cabinets, countertops, and other working surfaces were "unclean and littered with particles, dust, debris, splash, splatter, fingerprints and other identifiable spots that may have been blood" was covered with dirt, debris, splash, and/or splatter";

(d) The Office's Exposure Control Plan was "incomplete and many pages, especially pertaining to daily infection control procedures were left blank";

(e) The instrument preparation area was dirty, too small and cluttered with material and debris, without provision for the separation of clean and dirty instruments, creating a risk of cross contamination;

(f) Instruments cleaned in an ultrasonic device were bagged and stored on a filthy cloth towel;

(g) Debris was present on at least one handpiece inside a sterilization pouch, indicating that pre-cleaning was inadequate;

(h) The gloves used to prepare instruments were heavily soiled and filthy, as was the entire instrument preparation area;

(i) Devices such as curing lights and floss holders were not covered or disinfected;

(j) Instruments were placed on trays or tubs that were not properly cleaned;

(k) Burs were not properly cleaned;

(l) There was no self-contained water delivery system in any of the operatories;

(m) During patient care observed by the Expert, except for a barrier on the headrest of the patient chair, "no other barriers were in place";

(n) The barrier on the chair was not replaced between patients treated;

(o) The Respondent did not wear a gown when performing treatment, nor did his glasses have side-shields;

(p) The Respondent failed to perform hand hygiene before or after patient treatment.

13. Based on the above investigative facts, the Board has a basis to charge the Respondent with committing prohibited acts as set forth in the Act under H.O. § 4-315. Specifically, the Board finds that the Respondent violated one or more of the following subsections of H.O. § 4-315(a):

(16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]

(28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions[.]

CONCLUSIONS OF LAW

Based on the foregoing investigative findings, the Board concludes as a matter of law that the public health, safety, or welfare imperatively requires the immediate suspension of the Respondent's license to practice dentistry in Maryland, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2009 Repl. Vol. & 2013 Supp.).

ORDER

It is this 04th day of June, 2014, by a majority of the Board considering this matter:

ORDERED that pursuant to the authority vested in the Board by Md. State Gov't. Code Ann. § 10-226(c)(2), the Respondent's license to practice dentistry in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that the Respondent may request a hearing on the merits of this order for summary suspension. A request for a hearing must be in writing and be made **WITHIN THIRTY (30) DAYS** of service of this Order. The written request should be made to: Laurie Sheffield-James, Executive Director, Maryland State Board of Dental Examiners, 55 Wade Ave., Benjamin Rush Building, Spring Grove Hospital Center, Catonsville, MD 21228, with copies mailed to: Christopher Anderson, Administrative Prosecutor, Health Occupations Prosecution and Litigation Division, Office of the Attorney General, 300 West Preston Street, Suite 201, Baltimore, Maryland 21201, and Grant Gerber, Assistant Attorney General, Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201, and it is further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board his original massage dental license 8457, and any wallet card and wall certificate; and it is further

ORDERED that this is a Final Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq.(2009 Repl. Vol.).

06/04/2014
Date

Maurice S. Miles, D.D.S., President
Maryland State Board of Dental Examiners