IN THE MATTER OF	*	**BEFORE THE MARYLAND**
EFTEKHAR HASSANI, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 12040	*	**Case Number: 2004-136**

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CONSENT ORDER

On or about November 7, 2007, the Maryland State Board of Dental Examiners (the "Board") charged **EFTEKHAR HASSANI, D.D.S.** (the "Respondent"), date of birth: 03/21/54, License Number 12040, under the Maryland Dentistry Act (the "Act"), Md. Health Occ. Code Ann. (H.O.) §§ 4-101 *et seq.* (2000 Repl. Vol. & 2004 Supp.) for violations of H.O. § 4-315(a).

The Board charged the Respondent under the following provisions of the Act:

H.O. § 4-315

(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:

(3) Obtains a fee by fraud or attempts to obtain a fee by fraud;

(6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;

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

(20) Willfully makes or files a false report or record in the practice of dentistry.

As a result of negotiations with the Office of the Attorney General, by Robert J. Gilbert, Assistant Attorney General, and the Respondent, by Jonathan A. Cusson, Esquire, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, conclusions of Law, and Order, and with the terms and conditions set forth herein.

FINDINGS OF FACT

BACKGROUND FINDINGS

1. At all times relevant to the charges, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent initially received her license on March 16, 1998, under License Number 12040.

2. At all times relevant to the charges, the Respondent was affiliated with a dental practice known as Convenient Dental Care ("Convenient Dental"), located at 1726 North Rolling Road, Catonsville, Maryland 21244. The owner of Convenient Dental was Navid Asgari, D.M.D. Dr. Asgari became owner of Convenient Dental in or about 2001 and sold the practice in or about 2003.

3. The Board initiated an investigation of the Respondent after reviewing a complaint, dated November 13, 2003, from a former patient (hereinafter "Patient A")[1] who received treatment from her and Dr. Asgari at Convenient Dental from November 2002 to February 2003.

4. Patient A alleged that she scheduled an appointment to see an endodontist at Convenient Dental after her general dentist advised her that she possibly needed root canal therapy ("RCT"). Patient A alleged that during the course of

[1] For confidentiality purposes, patient names will not be used in this document. The Respondent is aware of the identity of all patients referred to in this document.

treatment, the Respondent and/or Dr. Asgari poorly performed dental procedures (i.e., placement of crowns on teeth # 14 and 19); misdiagnosed her dental problems and created more serious ones, for which she was still in treatment.

5. The Board then conducted a review of the Respondent's practice at Convenient Dental. The Board's investigative findings are set forth *infra*.

GENERAL FINDINGS

6. The Respondent practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of H.O. § 4-315(a)(6), when providing dental services to the patients that were reviewed. The Respondent cross-treated patients with the owner of Convenient Dental, Dr. Asgari, resulting in an intermingling of services and appointment dates. The Respondent failed to provide comprehensive dental care to patients. The Respondent failed to perform, or document performing, complete dental examinations. The Respondent failed to document that she reviewed her patients' medical/dental histories, and failed to undertake charting of her patients' decayed, missing, and filled teeth. The Respondent failed to undertake, or document undertaking, oral cancer screenings, or periodontal evaluations. The Respondent inappropriately provided antibiotic therapy in the absence of infective processes. The Respondent provided inappropriate dental restorations. The Respondent provided poor quality root canal therapy ("RCT") and bridgework, on at least one occasion, necessitating numerous revisions. The Respondent did not document the use or non-use of rubber dams in conjunction with RCT, and failed to document the use or non-use of working films or an apex locator when performing RCT.

PATIENT-SPECIFIC FINDINGS

Patient A

7. Patient A, then a 46-year old woman, scheduled an appointment at Convenient Dental on November 27, 2002, after her general dentist stated that she possibly needed RCT in tooth # 19 (which had an existing crown). The Respondent, a general dentist, saw Patient A on that date. The Respondent took radiographs of teeth # 14 and 19 and concluded that Dr. Asgari would need to evaluate the patient. Patient A was then scheduled for another appointment with Dr. Asgari.

8. Patient A returned for follow-up on December 10, 2002. Dr. Asgari was two hours late for Patient A's appointment. Dr. Asgari evaluated Patient A and concluded that there was no pathology in tooth # 19, but that tooth # 14 needed a build up and crown. Patient A was scheduled for another appointment.

9. Patient A returned for follow-up on December 17, 2002. The Respondent prepared tooth # 14 for a crown and placed a temporary crown on that tooth. During the procedure, Patient A reported that the Respondent injured Patient A's tongue with a dental drill. On December 17, 2002, the Respondent ordered porcelain-fused-to-metal ("PFM") crown for tooth # 14.

10. Patient A returned for follow-up on January 7, 2003. The Respondent placed a crown on tooth # 14. Patient A was dissatisfied with the appearance of the crown. The Respondent then took a new impression of tooth # 14. The Respondent took a radiograph of tooth # 19. Patient A also reported sensitivity in tooth # 19, and requested that Dr. Asgari see her.

11. Dr. Asgari then saw Patient A on January 7, 2003, and evaluated tooth # 19. Dr. Asgari took a periapical radiograph of tooth # 19 and recommended RCT with a post and core build-up of that tooth. Dr. Asgari did not perform RCT on this visit and reportedly wanted to see if Patient A's sensitivity diminished. Dr. Asgari did not note performing any diagnostic tests when evaluating this tooth. Dr. Asgari then instructed the Respondent to remove the crown from tooth # 19. The Respondent reportedly found and removed decay in that tooth. The Respondent then placed a filling material, and placed the pre-existing crown back on tooth # 19. Patient A reported that during this procedure, the Respondent "drilled [her] tongue again" and was oblivious to the occurrence until her assistant told her to stop.

12. Patient A returned for follow up on January 28, 2003, and was seen by the Respondent. The Respondent placed a crown on tooth # 14, and scheduled Patient A for RCT in tooth # 19 (which was noted to be asymptomatic). In her note, the Respondent stated that tooth # 14's occlusion, contacts and margins were "fine."

13. Patient A returned for follow up on February 4, 2003. The Respondent took an impression of tooth # 19 and prepared it for a crown. The Respondent scheduled Patient A for a return visit for placement of the crown. On February 4, 2003, the Respondent ordered a PFM crown for tooth # 19.

14. Patient A's dental record did not state that a crown was placed on tooth # 19.

15. Patient A returned to Convenient Dental on February 11, 2003, complaining of tongue pain. Dr. Asgari saw Patient A and recorded no signs of infection ("no inf").

16. Patient A then consulted with another dentist ("Dentist A") on July 3, 2003. Dentist A advised Patient A that: she had open margins on the crown on tooth # 14; she possibly needed to undergo crown lengthening on tooth # 14; she needed RCT on tooth # 19; and both crowns placed by Convenient Dental (teeth # 14 and 19) needed to be replaced.

17. On August 18, 2003, Patient A's previous dentist ("Dentist B") provided Patient A with a second opinion. Dentist B concurred with Dentist A's recommendations. Dentist B noted "questionable" occlusion on teeth # 14 and 19 and open margins on teeth # 14 and 19.

18. On August 26, 2003, underwent RCT on tooth # 19, performed by another dentist ("Dentist C").

19. On September 10, 2003, Dentist A placed a crown on tooth # 19.

20. On October 20, 2003, Dentist A removed the crown on tooth # 14 and recommended crown lengthening. Patient A underwent a crown lengthening procedure on tooth # 14, performed by Dentist A's associate ("Dentist D"), on October 22, 2003.

21. On December 12, 2003, Dentist A prepared tooth # 14 for a crown and placed a temporary crown.

22. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent injured Patient A's tongue on two occasions when providing dental services;

(b) the Respondent placed two crowns (teeth # 14 and 19) without evaluating, or documenting evaluating, Patient A's periodontal condition;

(c) the Respondent failed to undertake, or document undertaking, diagnostic testing results in evaluating the tooth for RCT;

(d) the Respondent placed crowns with open margins on teeth # 14 and 19;

(e) the Respondent misdiagnosed periapical pathology at tooth # 19; and

(f) the Respondent failed to identify decay in tooth # 18 when providing treatment to tooth # 19.

Patient B

23. Patient B, then a six-year old girl, received dental treatment from the Respondent on July 21, 2003. In the Patient History Report, the Respondent recorded providing a comprehensive oral examination, taking two bitewing radiographs, and performing a prophylaxis with fluoride treatment.

24. The Respondent failed to chart decayed, missing, and unerupted teeth.

25. The Respondent noted a dental plan that included placing fillings in four posterior teeth.

26. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to undertake, or document undertaking, a comprehensive oral examination; and

(b) the Respondent recorded a treatment plan that included placing fillings on four posterior teeth without evidence of undertaking radiographic or diagnostic evaluation, or providing graphic representation of the areas of decay in those teeth.

Patient C

27. Patient C, then a 32-year old woman, saw the Respondent on May 20, 2003, for an emergency examination for sensitivity of tooth # 3. The Respondent interpreted the radiograph as "everything WNL." The Respondent noted a treatment plan consisting of filling teeth # 2 and 3. Patient C's Patient History Report states that four periapical radiographs were taken on this visit. The Respondent prescribed Amoxicillin and Motrin.

28. Patient C returned on May 31, 2003, on which date the Respondent filled three surfaces on two teeth (# 2 and 3) and adjusted the occlusion on tooth # 3.

29. Patient C returned on July 19, 2003, complaining of sensitivity in tooth # 3. The Respondent removed the filling, placed a Vitrabond base and refilled the tooth with resin again.

30. Patient C returned on August 20, 2003. The Respondent performed an examination, took bitewing radiographs, performed a prophylaxis, and placed a one-surface filling in tooth # 28. The Respondent listed Patient C's periodontal status as I-II; noted that tooth # 3 was still causing pain on chewing, and was sensitive to hot and cold. The Respondent recommended RCT and prescribed Amoxicillin and Tylenol. The Respondent listed a treatment plan consisting of watching the mesial areas of teeth # 8

and 9; filling tooth # 15; and possible need for RCT, with post and core and crown for tooth # 3.

31. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient C's medical history; and

(b) the Respondent failed to record decayed, missing or filled teeth, the presence or absence of periodontal pockets, or other findings, such as oral cancer screening.

Patient D

32. Patient D, then a 74-year old man, and nursing home resident, saw the Respondent on one occasion, December 15, 2003. Patient D reported pain in the lower right quadrant, where a three-unit bridge (from tooth # 28 to 30) was in place. The Respondent noted general periodontal and gingival "hyperplasia" present. The Respondent noted taking a "FMX" (full mouth series of radiographs). The Respondent made a referral to a periodontist and prescribed Amoxicillin and Tylenol. Patient D's chart states that on December 8, 2003, he had been prescribed Augmentin (commercial product containing Amoxicillin and clavulanic acid) for five days.

33. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient D's medical history.

Patient E

34. Patient E, then a 62-year old man, was treated by the Respondent at Convenient Dental on June 12, 2002, for repair of a removable partial denture. The Respondent then treated Patient E on several follow-up visits. On August 26, 2002, the Respondent took an impression for a new mandibular partial denture.

35. On September 23, 2002, Dr. Asgari inserted the new mandibular partial denture. On November 21, 2002, the Respondent adjusted Patient E's mandibular partial denture.

36. Patient E continued to return for follow-up care. On March 4, 2003, Patient E came in for an emergency visit. Patient E pointed to tooth # 20, complaining of pain and sensitivity to cold, hot and pressure. The Respondent took a radiograph and noted decay in tooth # 19. The Respondent recommended possible surgical extraction of tooth # 19, or RCT if the tooth was restorable; and RCT on tooth # 20. The Respondent also prescribed an antibiotic, Amoxicillin.

37. Patient E returned on March 10, 2003. The Respondent performed an examination and took bitewing radiographs, and noted a treatment plan consisting of the extraction of teeth # 19 and 20.

38. Patient E returned on March 11, 2003, at which point the Respondent placed a MOD amalgam filling in tooth # 30. In her notes, the Respondent recorded this as "one big filling." On March 19, 2003, the Respondent placed a MOD amalgam filling in tooth # 31.

39. The Respondent performed RCT on tooth # 20 on May 24, 2003. Dr. Asgari completed RCT on tooth # 19 on June 18, 2003, and indicated placement of posts and cores and crowns on these teeth.

40. Patient E returned on July 2, 2003. The Respondent noted that tooth # 31 was fractured. The Respondent took a radiograph, and recommended possible RCT.

41. Patient E returned on July 3, 2003. The Respondent noted removing the mesial lingual and distal lingual cusps of tooth # 31. The Respondent noted that Patient E needed crown lengthening on tooth # 31, and that Patient E wanted the tooth extracted. The Respondent prescribed antibiotics and narcotic analgesics (Percocet) on this visit and referred Patient E for oral surgery.

42. The Respondent noted a treatment plan consisting of placement of posts and cores and crowns for teeth # 19 and 20. However, when Patient E returned on August 12, 2003, the Respondent performed crown buildups and crown preparations on teeth # 19 and 20 with no reference to posts or post size or cementing medium, and took an impression for a denture. The Respondent noted that on the next visit, she intended to place PFM crowns on teeth # 19 and 20. On August 21, 2003, the Respondent cemented these crowns.

43. The Respondent violated the Act, as set forth above, for reasons including, but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient E's medical history;

(b) the Respondent failed to note, or document noting, Patient E's periodontal status;

(c) the Respondent failed to perform, or document performing, diagnostic tests prior to recommending and performing RCT on tooth # 20;

(d) the Respondent failed to use, or document the use or non use of, a rubber dam when performing RCT;

(e) the Respondent failed to use, or document using, an apex locator prior to completing RCT;

(f) the Respondent failed to document the filling material used when performing RCT;

(g) the Respondent failed to document the presence of an infective process, when prescribing an antibiotic;

(h) the Respondent failed to note the use, type and amount of anesthesia used to treat tooth # 30 on March 11, 2003;

(i) the Respondent, in the Examination form, failed to document the presence or absence of decayed, missing, filled teeth, periodontal status, or document oral cancer screening; and

(j) the Respondent, in Patient E's Patient History Report for August 12, 2003, listed providing posts and cores for teeth # 3, 19, and 20. The Respondent's treatment notes limit the services recorded as crown buildups only.

Patient F

44. Patient F, then a 61-year old woman, saw Dr. Asgari in September 2002. Dr. Asgari diagnosed left lower discomfort and prescribed Kenalog ointment.

45. Patient F returned on November 8, 2002. The Respondent noted performing an examination, and noted a treatment plan consisting of placing three surfaces to be filled in teeth # 21 and 28, and placing a lower partial denture and upper complete denture.

46. Patient F returned on April 17, 2003. The Respondent noted removing the amalgam filling from tooth # 21, removing decay and exposing the dental pulp. The Respondent initiated RCT on this tooth, and performed a pulpotomy. The Respondent prescribed a narcotic analgesic, Tylenol # 3, and an antibiotic, clindamycin, in the absence of documented infective process.

47. Patient F returned on July 1, 2003, at which point the Respondent completed RCT on tooth # 21.

48. Patient F returned on August 15, 2003. The Respondent noted performing crown buildups on teeth # 21 and 28. The Respondent noted that crown preparations would be performed on the next visit.

49. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient F's medical history;

(b) the Respondent failed to provide documentation about the presence or absence of decayed, missing, and filled teeth, performance of periodontal evaluation with pocket probings, and oral cancer screening;

(c) the Respondent prescribed an antibiotic in the absence of documented infective process;

(d) the Respondent failed to take diagnostic radiographs prior to establishing a treatment plan and attempting to restore tooth # 21, resulting in pulpal exposure, and the need for RCT on that tooth;

(e) the Respondent failed to document the use or non-use of a rubber dam isolation when performing RCT;

(f) the Respondent failed to use, or document using, a "working film" or record readings of an apex locator to verify dimension used as 19 mm.; and

(g) the Respondent failed to document the filling material or the cementing material used when sealing the RCT.

Patient G

50. Patient G, then a 25-year old woman, saw the Respondent on November 5, 2002. The Respondent performed an examination and took bitewing radiographs. The Respondent noted that Patient G's periodontal status was I-II, with pockets ranging from one to five mm. The Respondent noted a plan of treatment consisting of FMD, 22 surfaces of fillings in 10 teeth, plus a crown buildup and crown on tooth # 19.

51. Patient G returned on December 19, 2002, at which point the Respondent performed a full mouth debridement.

52. Patient G returned on September 20, 2003. The Respondent placed a two-surface amalgam filling in tooth # 12.

53. Patient G continued to return to Convenient Dental for follow-up treatment. On March 3, 2004, Patient G had bitewing radiographs taken. These radiographs show that the amalgam filling Dr. Asgari placed in tooth # 5 appeared to be fracturing, has an overhanging margin, and recurrent decay. On this date, the Respondent placed a three-surface resin filling in tooth # 4.

54. The Respondent violated the Act for reasons that include, but are not limited to the following:

(a) the Respondent failed to document that she reviewed Patient G's medical history;

(b) the Respondent failed to provide documentation about the presence or absence of decayed, missing, and filled teeth, performance of periodontal evaluation with pocket probings, and oral cancer screening;

(c) the Respondent failed to provide a periodontal evaluation, charting or recording of bleeding sites, mobility, when noting Patient G's periodontal status; and

(d) the Respondent's treatment plan includes placing many fillings, although radiographs do not confirm the need.

Patient H

55. Patient H, then a 23-year old man, first saw the Respondent on July 18, 2003, with pain in the lower right quadrant. The Respondent took a radiograph of tooth # 31 and prescribed Amoxicillin and Tylenol # 3. The Respondent listed a treatment plan consisting of RCT, post and core, and crown.

56. Patient H returned on July 25, 2003, at which point the Respondent initiated RCT in tooth # 31. The Respondent noted that the dimensions of all four canals were 20 mm. The Respondent again prescribed Amoxicillin and Tylenol # 3.

57. On August 6, 2003, the Respondent carried out the second phase of the RCT in tooth # 31, took a radiograph and provided a buildup of tooth # 14, with no documentation of a post or referencing post size. The Respondent again prescribed Amoxicillin and Tylenol # 3.

58. On September 4, 2003, the Respondent placed a resin filling in tooth # 30 and a post and core in tooth # 31. The Respondent noted a treatment plan for crowning teeth # 14 and 31.

59. The Respondent violated the Act, as set forth above, for reasons that include but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient H's medical history;

(b) the Respondent caused a perforation and a broken instrument sealed in one canal when undertaking RCT in tooth # 31;

(c) the Respondent failed to document the use or non-use of a rubber dam isolation when performing RCT;

(d) the Respondent prescribed antibiotics in the absence of documented infective process; and

(e) the Respondent failed to document appropriate Informed Consent.

Patient I

60. Patient I, then a 42-year old woman, initially saw the Respondent on November 13, 2002. The Respondent performed an examination, prophylaxis, and took bitewing radiographs. The Respondent noted a treatment plan consisting of placing four surfaces of fillings in two teeth, and a buildup and crown in tooth # 19.

61. The Respondent performed a buildup of tooth # 19 on December 18, 2003.

62. Patient I returned on April 22, 2003 for recementation of a crown on tooth # 30. On this date, the Respondent prepared tooth # 19 for a crown.

63. On June 5, 2003, the Respondent cemented the crown on tooth # 19 and took a radiograph. Patient I reported pain in tooth # 15. The Respondent took a radiograph of this tooth and prescribed an antibiotic, clindamycin. Patient I returned on June 6, 2003, at which point the Respondent performed a pulpotomy in tooth # 15.

64. Patient I returned for follow-up on July 22, 2003, at which point the Respondent referred her to an endodontist.

65. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient I's medical history;

(b) the Respondent failed to provide documentation about the presence or absence of decayed, missing, and filled teeth, performance of periodontal evaluation with pocket probings, and oral cancer screening; and

(c) the Respondent prescribed an antibiotic in the absence of documented infective process.

Patient J

66. Patient J, then a nine-year old boy, saw the Respondent on June 14, 2003. The Respondent performed an examination, prophylaxis, took bitewing radiographs, and provided fluoride treatment. The Respondent noted an abscess on tooth # L.

67. Patient J returned on June 30, 2003. The Respondent noted extracting tooth # L. Patient J's Patient History Report, however, notes that tooth # J was extracted on this visit. The Respondent subsequently filled tooth # T on August 4, 2003.

68. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient J's medical history; and

(b) the Respondent failed to provide documentation about the presence or absence of decayed, missing, filled and unerupted teeth.

Patient K

69. Patient K, then a 31-year old woman, first saw Dr. Asgari on January 21, 2003, for pain in tooth # 15. Dr. Asgari prescribed an antibiotic, Amoxicillin, and planned to perform RCT on this tooth.

70. Patient K then returned for follow-up on February 22, 2003. The Respondent performed RCT on tooth # 13. The Respondent then performed RCT on tooth # 15 on March 4, 2003 and March 20, 2003. On both visits, the Respondent

prescribed Amoxicillin. During the course of performing RCT, the Respondent perforated the pulpal floor between the roots of tooth # 15.

71. On March 25, 2003, Dr. Asgari's treatment notes state that he performed a post and core build up of teeth # 13 and 15; and crown lengthening on tooth # 13. The Respondent wrote this treatment note, which Dr. Asgari did not sign or initial. Patient K's radiographs do not show that Dr. Asgari placed a post and core on tooth # 15, although the documentation in the treatment notes indicates that a post and core were provided for tooth # 15.

72. Patient K returned on April 12, 2003, at which point the Respondent placed a three unit bridge from tooth # 13 to tooth # 15. The Respondent noted that she checked the margins, contact and occlusion.

73. Patient K returned on May 9, 2003, complaining of sensitivity. The Respondent took a radiograph of the bridge and a periapical radiograph and stated that the area was within normal limits. The Respondent placed Patient K on Amoxicillin and scheduled Patient K for a return visit. Patient K's radiographs show an open margin on tooth # 15, radiolucency around the filled area, and fails to cover the distal aspect of the crown buildup.

74. On June 17, 2003, Dr. Asgari extracted tooth # 15. Dr. Asgari noted removing tooth # 14, however, in Patient K's treatment notes. Dr. Asgari prescribed a narcotic analgesic, Vicodin. Dr. Asgari noted a new plan of treatment, placement of a fixed bridge from tooth # 13 to tooth # 16.

75. On August 7, 2003, Patient K returned for follow up. The Respondent prepared tooth # 16 as the posterior retainer for a four-unit bridge.

76. Patient K returned for follow-up on September 2, 2003. The Respondent placed the fabricated bridge and took a radiograph. The radiograph shows on open margin on tooth # 16 and does not visualize the apical area of this tooth. The Respondent then took a new impression because of open margins on tooth # 13 and tooth # 16.

77. Patient K returned on December 3, 2003, at which point the Respondent attempted to place the bridge, but noted an open margin on tooth # 13. The Respondent then took a new impression.

78. Patient K returned on December 15, 2003. The Respondent placed the new bridge that had been fabricated, and noted open margins on tooth # 13 and tooth # 15.

79. Patient K returned on December 20, 2003, and was seen by Dr. Asgari. Dr. Asgari assessed the bridge that had been repeatedly processed and reprocessed by the Respondent due to marginal integrity problems. Dr. Asgari reduced the pontic area of the bridge, noted, "margins are fine," and cemented the bridge.

80. The Respondent violated the Act for reasons that include, but are not limited to the following:

(a) the Respondent failed to document that she reviewed Patient K's medical history;

(b) the Respondent, during performance of RCT, perforated the root of tooth # 15, which ultimately necessitated removal of the tooth, and extension of the three-unit bridge to a four-unit bridge; and

(c) the Respondent failed to execute an Informed Consent form or document verbal informed consent of the risks and benefits for the bridgework provided.

Patient L

81. Patient L, then a nine-year old boy, was initially seen by a dentist at Convenient Dental on August 31, 2001. The Respondent first saw Patient L on June 28, 2003, when Patient L was 11-years old. The Respondent performed an examination, prophylaxis, took bitewing radiographs, provided fluoride treatment, and oral hygiene instructions. The Respondent noted a treatment plan that included filling two surfaces in two teeth.

82. Patient L returned for follow-up treatment on August 9, 2003. The Respondent placed a two-surface filling in tooth # 3 and while preparing tooth # 19 for a filling procedure, exposed the pulp. The Respondent performed a pulpotomy and prescribed Amoxicillin.

83. On August 11, 2003, the Respondent initiated RCT on tooth # 19. The Respondent finished the procedure on September 13, 2003, noting that she filled all canals at 19 mm. The Respondent did not note using an apex locator or working films.

84. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient L's medical history;

(b) the Respondent caused a pulpal exposure when attempting to prepare and fill tooth # 19;

(c) the Respondent failed to document the use or non-use of a rubber dam isolation when performing RCT;

(d) the Respondent failed to use, or document using, a "working film" or record readings of an apex locator to verify dimension used as 19 mm.; and

(e) the Respondent failed to document appropriate Informed Consent to Patient L's parent.

Patient M

85. Patient M, then an 11-year old boy, was initially treated by the Respondent on December 11, 2002. On this date, the Respondent provided an examination, prophylaxis, took bitewing radiographs, provided fluoride treatment and oral hygiene instructions. The Respondent noted a treatment plan that included four surfaces of fillings in three teeth.

86. Patient M returned for follow-up treatment on August 5, 2003. The Respondent attempted to fill tooth # 30. During the process of clearing decay, the Respondent entered the pulp of the tooth, and initiated RCT. The Respondent also prescribed Amoxicillin.

87. The Respondent completed RCT on December 24, 2003, with instrumentation and obturation with Thermafil. The Respondent against prescribed Amoxicillin.

88. Patient M was then seen by another dentist on February 16, 2004, who noted that Patient M had a "significant perforation at the floor of the pulp chamber" in

tooth # 30. As a result, this dentist referred Patient M to an endodontist for an evaluation and possible extraction of tooth # 30.

89. The Respondent violated the Act, as set forth above, for reasons including but not limited to the following:

(a) the Respondent failed to document that she reviewed Patient M's medical history;

(b) the Respondent, when preparing tooth # 30 for filling, exposed the pulp;

(c) the Respondent failed to document the use or non-use of a rubber dam isolation when performing RCT;

(d) the Respondent perforated the floor of the pulp chamber of tooth # 30 when performing RCT on that tooth;

(e) the Respondent filled the root canal of tooth # 30 with Thermafil during RCT, although perforation was apparent; and

(f) the Respondent prescribed antibiotics in the absence of documented infective process.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the following provision of the Maryland Dentistry Act: H.O. § 4-315(a)(6) (Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is by a majority of the quorum of the Board considering this case hereby:

ORDERED that the Respondent's be and hereby is **REPRIMANDED**; and it is further

ORDERED that the Respondent shall be subject to the following terms and conditions, to commence on the date the Board executes this Order:

1. That the Respondent shall continue cessation of performing endodontics; however, the Respondent is not precluded from petitioning the Board to resume endodontics. Such Petition shall include an assessment of the Respondent's abilities by a Board approved practice reviewer who has been engaged by the Respondent at her own expense. The practice reviewer, with prior approval from the Board, shall observe the Respondent perform no less than 12 root canal procedures. The reviewer shall provide the Board with a written report noting her or his findings and recommendations; and it is further

2. Within ninety (90) days of the date the Board executes this Consent Order, the Respondent shall take and successfully pass the Dental Simulated Clinical Exercise ("DSCE") provided by the American Association of Dental Examiners, Inc., which includes units on: Diagnosis, Oral Medicine and Radiology (the DOR), Comprehensive Treatment Planning (the CTP), Periodontics, Prosthodontics, and Medical Considerations (the PPMC), with the following provisions:

   a. The Respondent shall authorize release of the results to the Board, or release to the Board her results upon their receipt;

   b. If required by the Board, the Respondent shall appear before

the Board Case Resolution Conference panel to determine if any other remedial courses are necessary in addition to those specified below, based on the results of the DSCE; and

c. The Respondent shall comply with all course work recommendations made by the Board based on the results of the DSCE.

3. Within nine (9) months of the date the Board executes this Consent Order, the Respondent shall successfully complete an extensive, Board-approved course in diagnosis and treatment planning;

4. Within nine (9) months of the date the Board executes this Consent Order, the Respondent shall successfully complete an extensive, participation based, Board-approved course in restorative dentistry, focusing on prosthodontics and not cosmetic dentistry;

5. Within nine (9) months of the date the Board executes this Consent Order, the Respondent shall successfully complete an extensive, Board-approved course in the diagnosis and treatment of periodontal disease;

6. Within nine (9) months of the date the Board executes this Consent Order, the Respondent shall successfully complete an extensive, participation based, Board-approved course in composite and amalgam restorations;

7. Within twelve (12) months of the date the Board executes this Consent Order, the Respondent shall successfully complete a Board-approved course in billing and CDT coding;

8. The Respondent's practice of dentistry shall undergo monitoring by a Board-approved clinical practice reviewer (the "reviewer") in general dentistry for a minimum of eighteen (18) months (the "review period"), as follows:

a. The Respondent shall permit the reviewer to directly observe the Respondent's treatment of patients, during at least one ½ day unannounced visit weekly for the first three (3) months of the review period and every month thereafter for the first year of the review period and on additional unannounced visits thereafter as recommended by the reviewer, or the Board, but not less than quarterly, for the duration of the review period;

b. The Respondent shall permit the reviewer to make unannounced visits for direct observation of the Respondent's treatment of patients, at the discretion of the reviewer, or the Board; and the Respondent shall permit direct observation of performance of certain procedures by a specialist, if recommended by the reviewer, or the Board;

c. The Respondent shall permit the reviewer to conduct unannounced on-site random chart review of at least eight (8) patient charts, every 30 to 60 days, for a minimum of six (6) visits within the first year of the review period, and at least twice during the next six (6) months;

d. The Respondent shall provide to the reviewer the complete record for each patient whose care is being reviewed. The reviewer shall focus on the care and treatment rendered by the Respondent from 2008 and thereafter;

e. The Respondent shall make all reasonable efforts to ensure that the reviewer, and the specialist(s), if any, submit written reports to the Board and the Respondent within thirty (30) days of each visit to Respondent's office describing the findings and making recommendations for improvement;

f. The Respondent shall comply with all written recommendations of the reviewer, the specialist(s), if any, or the Board. Failure to comply with the written recommendations, unless otherwise approved by the Board after evaluation of a written submission from the Respondent, shall be deemed a violation of the Consent Order; and

g. If, at the end of the 18 month review period, the reviewer determines that the Respondent could benefit from additional oversight, the Board may extend the period of review for up to an additional year wherein quarterly reviews could occur.

AND BE IT FURTHER ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with the reviewer, 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 any finding by the Board indicating that the Respondent fails to take the DSCE, fails to complete the required courses, fails to have the practice reviews, fails to cooperate with the practice reviewer, fails to follow the written recommendations of the practice reviewer or the Board as delineated in ¶ 8f above, or that the Respondent's dental care or record keeping fails to meet appropriate standards, may constitute a violation of this Order and may, in the Board's discretion, be grounds for immediately suspending the Respondent's license. In the event that the Respondent's license is suspended under this provision, she shall be afforded a Show Cause Hearing before the Board to show cause as to why her license should not be suspended; and it is further

ORDERED that the Respondent shall comply with and practice within all statutes and regulations governing the practice of dentistry in the State of Maryland; 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 the Respondent may petition the Board, in writing, for termination of this Consent Order without further conditions or restrictions only if the Respondent has satisfactorily complied with all conditions of this Consent Order and the Respondent has no pending complaints before the Board; and it is further

ORDERED that any violation of any of the terms of this Consent Order shall constitute unprofessional conduct in addition to any other applicable grounds under the Act; and it is further

ORDERED that the charges under H.O. §§ 4-315(a) (3), (16), and (20) are hereby dismissed; and be it further

ORDERED that this Order is a public document pursuant to Md. State Gov't Code Ann. §§ 10-611, *et seq.* (2004).

4/16/08
Date of Consent Order

David A. Williams, D.D.S.
President
Board of Dental Examiners

CONSENT OF EFTEKHAR HASSANI, D.D.S.

I, Eftekhar Hassani, D.D.S., License No. 12040, by affixing my signature hereto, acknowledge that:

1. I am represented by counsel and have reviewed this Consent Order with my attorney, Jonathan A. Cusson, Esquire before signing this Consent Order.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 4-318 (2005 Repl. Vol.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2004 Repl. Vol.).

3. I acknowledge the validity of this Consent Order as if entered into after 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 am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order as set forth in § 4-318 of the Act and Md. State Gov't Code Ann. or any adverse ruling of the Board that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary action following proper procedures, which may include revocation of my license to practice dentistry in the State of Maryland.

6. I sign this Consent Order voluntarily, without reservation. I fully understand and comprehend the language, meaning, and terms of this Consent Order.

04-03-08
Date

Eftekhar Hassani, D.D.S.
Respondent

Reviewed and approved by:

04-03-08
Date

Jonathan A. Cusson, Esquire
Attorney for the Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF :

I HEREBY CERTIFY that on this 3rd day of April, 2008 before me, a Notary Public of the State and County aforesaid, personally appeared Eftekhar Hassani, D.D.S., License number 12040, and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 6/1/09