

IN THE MATTER OF
DONALD PARKER, D.D.S.

Respondent

License Number: 4871

* BEFORE THE MARYLAND
* STATE BOARD OF
* DENTAL EXAMINERS
* Case Number: 2007-242

* * * * *

CONSENT ORDER

The Maryland State Board of Dental Examiners (the "Board") on January 6, 2010 charged DONALD PARKER, D.D.S. (the "Respondent"), D.O.B. 05/19/41, License Number 4871, under the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occupations ("Health Occ.") §§ 4-101 *et seq.* (2009 Repl. Vol.). The pertinent provisions of the Act and those under which these Charges are based are as follows:

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 deny a general license to practice dentistry, a limited license to practice dentistry, or a teacher's license to practice dentistry to any applicant, reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:

(6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner[.]

In February 2010, the Office of the Attorney General, by and through Tracee Orlove Fruman, Assistant Attorney General, and the Respondent, by and through his attorney, Catherine A. Hanrahan, Esquire, entered into negotiations in an attempt to resolve the charges against the Respondent without the need for an evidentiary hearing. As a result of those negotiations, the Respondent agreed to enter into this

Consent Order consisting of Procedural Background, Findings of Fact, and Order, with the terms and conditions set forth below.

PROCEDURAL HISTORY

2000 Consent Order

1. By letter dated January 5, 2000, the Board notified the Respondent that he was not in compliance with the Centers for Disease Control ("CDC") guidelines on universal precautions, in violation of Health Occ. § 4-315(a)(28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control guidelines on universal precautions.

2. The Board alleged that the Respondent, *inter alia*, failed to spore test the office autoclave, failed to disinfect contaminated surfaces and/or remove protective barriers between patients, and failed to wash hands as required. In addition, the Board alleged that the Respondent's office lab, where prostheses and prosthodontic materials were kept was unclean and showed evidence of roach infestation.

3. On or about May 17, 2000, the Board and the Respondent entered into a Consent Order ("2000 Consent Order") to resolve the charge against the Respondent that he was not in compliance with the CDC guidelines on universal precautions.

4. The 2000 Consent Order found that the respondent violated Health Occ. § 4-315(a)(28) and ordered that the Respondent abide by certain terms and conditions. Specifically, the Respondent was ordered to retain a consultant to evaluate his office and train the Respondent on the implementation of CDC guidelines in his dental practice; complete a Board-approved continuing education course in CDC guidelines; and allow for unannounced CDC inspections of his dental practice by the Board.

5. The penalty for failing to comply with the 2000 Consent Order was suspension of the Respondent's dental license.

6. The 2000 Consent Order was terminated on July 5, 2001 after the Respondent fully complied with its requirements.

2005 Summary Suspension, Consent Order and Order for Reinstatement and Order of Probation

7. On or about July 11, 2005, the Board summarily suspended the Respondent's license to practice dentistry in Maryland.

8. The summary suspension was based upon a complaint that alleged that the Respondent used un-sterile instruments and did not wear gloves during treatment. The complaint also alleged that the Respondent's office did not have running water and the "rinse bowl" was rusty.

9. The Board conducted an investigation and unannounced inspection of the Respondent's office which revealed, *inter alia*, the use of contaminated instruments for patient care, failure to spore test autoclaves, cross-contamination of surfaces, equipment and instruments, little to no running water, and failure to use personal protective equipment.

10. By an Order Continuing Summary Suspension dated August 5, 2005, the summary suspension of the Respondent's license was continued.

11. On or about September 5, 2005, the Board and the Respondent entered into a Consent Order ("2005 Consent Order"). The 2005 Consent Order found that the respondent violated Health Occ. § 4-315(a)(6), (16), and (28).

12. Pursuant to the 2005 Consent Order, the Respondent's license was suspended for a period of six months beginning July 11, 2005, and the suspension was

stayed on November 3, 2005 subject to certain conditions. The Respondent was ordered to retain a Board-approved consultant to evaluate his office and train the Respondent and his employees on the implementation of CDC guidelines in his dental practice and repair the water lines in each operatory. Upon reinstatement, the Respondent's license would be placed on probation for a period of three years with conditions.

13. By an Order for Reinstatement and Order of Probation dated November 25, 2005, the Respondent's license was reinstated and he was placed on probation for a period of three years with conditions including but not limited to having his practice observed by a consultant, a minimum of four unannounced inspections per year by the consultant and random unannounced inspections by the Board and/or the consultant.

14. The Respondent fully completed the requirements of the Order of Probation, and by an order dated December 17, 2008, the Respondent's license was restored without restrictions or conditions.

FINDINGS OF FACT

The Board bases its charges on the following facts that the Board has cause to believe are true:

15. At all times relevant to these charges, the Respondent was and is licensed to practice dentistry in the State of Maryland, having been issued license number 4871.

16. At all times relevant to these charges, the Respondent maintained an office for general dentistry located at 5443 Park Heights Avenue, Baltimore, Maryland 21228.

Patient A¹

17. On or about March 21, 2007, the Board received a copy of a health care claim that had been filed with the Director of the Health Care Alternative Dispute Resolution Office alleging negligent medical and/or dental care against several health care providers, including the Respondent.

18. The Board opened an investigation into this matter.

19. The claim alleged that on March 2, 2004, the claimant ("Patient A"), a 40 year-old female, presented to the office of Dr. A complaining of a facial abscess or cyst on the right side of her chin. Dr. A diagnosed Patient A with a draining sinus with intermittent abscess formation, secondary to a necrotic tooth root. Dr. A placed Patient A on antibiotics and referred her to her dentist, the Respondent, for extraction of the necrotic tooth.

20. On the same day, Patient A presented to the Respondent's office. On her patient registration form, the Respondent stated that the purpose of the appointment was "needs to have a tooth removed."

21. A review of Patient A's record revealed that the Respondent performed an exam, extracted teeth ##28, 29, and 30 and placed sutures.

22. According to the Respondent's notes, the Respondent did not take radiographs of Patient A to determine the extent of the lesion and what teeth were involved prior to extracting her teeth. Further, the Respondent failed to document any diagnosis, findings or observations, such as probing depths, mobility, swellings, general appearance of patient, odors from swelling or drainage, temperature, sensitivity, pulp

¹ To protect confidentiality, the names of patients and health care providers other than the Respondent are not used in this charging document. The Respondent may obtain a listing of the names from the Administrative Prosecutor.

testing or percussion. In addition, the Respondent failed to document the type and amount of anesthetic used, if any, for the tooth extractions. The Respondent also failed to document a diagnosis to support the extraction of Patient A's teeth.

23. Further, Patient A's file does not contain an appropriate written informed consent authorizing the extraction of her teeth, nor did the Respondent document that he had obtained appropriate verbal consent from Patient A. There are no notations in Patient A's files regarding any discussion of alternative treatment options.

24. Based upon the Respondent's lack of documentation, there is no evidence that the treatment rendered was clinically indicated.

25. Patient A returned to the Respondent's office on March 26, 2004. The Respondent documented, "observation – next visit Panorex (x-ray)". Due to the Respondent's inadequate documentation, it is unclear why the Respondent would need to take a panoramic radiograph of Patient A at a future visit. The Respondent failed to document suture removal, healing, or whether there was any change with respect to Patient A's swelling.

26. There is no documentation in Patient A's file that the Respondent referred Patient A to an oral surgeon.

27. Patient A continued to experience pain and swelling over the following months and treatments prescribed by various physicians did not resolve her symptoms. On May 27, 2005, an MRI indicated osteomyelitis of the right mandible.

28. On August 19, 2005, Patient A underwent a surgical procedure in which the osteomyelitic mandible bone was excised and her mandible was reconstructed using her right fibula bone. Patient A was discharged to a rehabilitation center because

the bone excisions from her jaw and fibula rendered her unable to eat normally and unable to walk. Patient A remained in a rehabilitation center until October 6, 2005.

29. As part of the Board's investigation, the Board reviewed five additional patient records ("Patients B, C, D, E, and F").

Patient B

30. On May 15, 2008, Patient B, a 24-year-old female, presented to the Respondent to have a tooth pulled.

31. In Patient B's file, the Respondent noted "home care poor, chief complaint pain, need ext., need peri [and] prophyl."

32. During that visit, the Respondent performed an examination, extracted teeth #3 and 28, and put in three sutures. The Respondent documented the type and quantity of anesthesia used and that he provided home care instructions to Patient B.

33. The Respondent failed to document any findings or observations, such as probing depths, mobility, swellings, general appearance of patient, odors from swelling or drainage, temperature, sensitivity, pulp testing or percussion. Further, there is no documentation of a diagnosis to support extraction of Patient B's teeth.

34. The Respondent documented that he took radiographs of Patient B's teeth. However, the radiographs were cone cut, did not show complete root anatomy and did not show the relationship to the sinus and nerve areas. As a result, the radiographs were inadequate for use as a diagnostic and/or treatment tool to support the treatment provided by the Respondent.

35. Patient B's file does contain a written informed consent form, entitled "Authorization for Dental Treatment," which is signed by Patient B. The Respondent's

signature and the date (May 15, 2008) are stamped on the form, rather than handwritten.

36. Based upon the Respondent's lack of documentation and the poor quality of the radiographs, the record fails to support the treatment as clinically indicated.

Patient C

37. Patient C, a 68-year-old male, presented to the Respondent on April 27, 2007 to be fitted for a denture, according to Patient C's medical and dental history form.

38. The Respondent's notes state that he conducted an exam, extracted tooth #5 and placed two sutures. The Respondent documented the type and quantity of anesthesia used and that he provided home care instructions to Patient C.

39. The Respondent failed to document any findings or observations, such as probing depths, mobility, swellings, general appearance of patient, odors from swelling or drainage, temperature, sensitivity, pulp testing or percussion. Further, there is no documentation of a diagnosis to support the extractions.

40. Patient C's file does contain a written informed consent form, entitled "Authorization for Dental Treatment," which is signed by Patient C. The Respondent's signature and the date (April 27, 2007) are stamped on the form, rather than handwritten. Further, the form authorizes extraction of teeth ## 5 and 30, even though tooth #30 was not extracted until August 8, 2007.²

41. The Respondent apparently took radiographs prior to extracting the teeth, however, there is no mention of the radiographs in the Respondent's handwritten notes. Further, the radiographs are not dated. The radiographs lack detail and the upper right quadrant periapical radiograph does not show the complete root, apex or sinus.

² The form also indicates that informed consent was obtained as to a lower-partial denture.

Therefore, the radiograph is not of diagnostic quality and is an inadequate treatment tool.

42. The Respondent failed to document any discussion regarding alternative treatment plans.

43. On May 4, 2007, Patient C presented to the Respondent for a follow-up appointment. According to Patient C's file, the Respondent removed the sutures. The Respondent noted, "next visit add tooth #5 to partial," but failed to document any information about Patient C's healing.

44. On August 8, 2007, Patient C presented to the Respondent for "exam, prophylaxis" and removal of tooth #30.³ There is no diagnosis or observations documented to support the extraction of tooth #30.

45. The Respondent documented the placement of sutures, the type and quantity of anesthesia used, and that post-operative instructions were given to Patient C. Also, the Respondent wrote, "left mesial root tip" but did not elaborate.

46. On March 5, 2008, Patient C presented to the Respondent for "exam, prophylaxis and removal of root tip #30 (mesial)." The Respondent documented that he placed one suture, as well as the type and quantity of anesthesia used. There is no evidence that the Respondent took radiographs to determine if any other root tips remained.

47. On March 12, 2008, the Respondent removed Patient C's sutures, but did not document any information regarding healing.

³ Patient C also presented to the Respondent on May 11, 2007, June 22, 2007, March 19, 2008 and March 26, 2008. However, those visits were related to Patient C's dentures.

48. Based upon the Respondent's lack of documentation, the poor quality of the radiographs taken of the upper right quadrant, and his failure to take radiographs of the lower right quadrant, the record fails to support the treatment as clinically indicated.

Patient D

49. Patient D, a 51-year-old female, presented to the Respondent on January 31, 2008 for the extraction of three teeth. Patient D's file contains a written informed consent form, entitled "Authorization for Dental Treatment," which is dated and signed by Patient D and the Respondent and provides informed consent for the extraction of teeth ## 11, 13 and 14.

50. The Respondent documented "very poor home care," but failed to document any observations in support of tooth extraction or a diagnosis.

51. The Respondent took two undated periapical radiographs but they are of very poor quality and are inadequate as a diagnostic and/or treatment tool. The radiographs are blurry, cone cut, and show only clinical crowns. The root structure and sinus involvement are not visible on the radiographs. Further, the radiographs do not show any pathology because the apex is not visible.

52. The Respondent documented that he performed an exam, extracted teeth ## 11, 13, and 14, placed four sutures, and the type and quantity of anesthesia used.

The Respondent documented that Patient D was provided with instructions and given Motrin 800mg.

53. According to Patient D's file, she did not return to the Respondent for suture removal or for any future appointments.

54. Based upon the Respondent's lack of documentation and the poor quality of the radiographs taken, there is no evidence that the treatment rendered was clinically indicated.

Patient E

55. Patient E, a 31-year-old male, presented to the Respondent on March 7, 2008 with a chief complaint of "pain lower right." The Respondent noted that Patient E had fair home care and "will need other treatment."

56. The Respondent documented that he performed an exam, extracted tooth #30, took one radiograph, and the type and quantity of anesthesia used. He documented that Patient E was given instructions and placed on antibiotics.

57. The Respondent failed to document any observations or diagnosis in support of the extraction of tooth #30.

58. The radiograph adequately shows the tooth and supports the extraction, however the radiography is irregular in that it contains debris throughout the image.

59. Patient E's file contains a written informed consent form, entitled "Authorization for Dental Treatment," which is dated and signed by Patient E and the Respondent and provides informed consent for the extraction of tooth # 30. However, Patient E's medical and dental history form is signed only by the Respondent and not by

Patient E:

60. Although the treatment provided by the Respondent is supported by the radiograph, the Respondent's documentation is limited and falls below the standard of care.

Patient F

61. Patient F, a 63-year-old male, presented to the Respondent on December 8, 2007 for extraction of several teeth and a full denture.

62. Patient F's file does contain a signed and dated written informed consent form authorizing the extraction of teeth ##21 through 27. However, Patient F's medical and dental health form is not signed by the Respondent.

63. The Respondent documented that he performed an exam, took three apical radiographs and placed Patient F on antibiotics. There is no documentation in support of the Respondent's prescription of antibiotics for Patient F, although his medical and dental health form indicates that he is a diabetic.

64. The radiographs of teeth ##22 through 26 were not of diagnostic and/or treatment quality because they do not show the complete root formation and the apex region. In addition, the radiographs of teeth ## 21 and 27 were cone cut, do not show the apex region, and are of poor quality. Further, the radiographs were not dated.

65. On December 12, 2007, the Respondent documented that he extracted teeth ## 21 and 27 and placed two sutures. The Respondent documented the type and quantity of anesthesia used, and that instructions were given to Patient F. The Patient was also instructed to continue taking the antibiotics until the next visit. There is no documentation to substantiate the need for antibiotics, although Patient F's medical and dental health form indicates that he is a diabetic.

66. At Patient F's next visit on December 18, 2007, the Respondent documented that he removed the sutures and took impressions. Patient F saw the

Respondent twice more in December 2007 for appointments related to Patient F's dentures.

67. On January 25, 2008, the Respondent documented that he placed Patient F on antibiotics to be started one day before his next visit. However, there is no documentation to indicate why antibiotics were prescribed for Patient F.

68. On February 1, 2008, Patient F presented to the Respondent for extraction of teeth ##22, 23, 24, 25 and 26. The Respondent documented that he used continuous, plain gut sutures, as well as the type and quantity of anesthesia.

69. Patient F saw the Respondent for two additional appointments relative to his new denture.

70. With respect to Patient F, the Respondent's documentation lacks a written diagnosis and any discussion of whether an alternative treatment plan was considered. Further, Patient F's file contains no periodontal documentation, or any notes regarding probings, percussion, temperature or pulp testing. It is noted that all remaining teeth were very mobile.

71. Based upon the Respondent's lack of documentation and the poor, non-diagnostic quality of the radiographs, the record fails to support that the treatment rendered was clinically indicated.

72. The Respondent's inadequate documentation, failure to take radiographs when necessary, and failure to take radiographs of diagnostic quality constitute, in whole or in part, practicing dentistry in a professionally incompetent manner in violation of Health Occ. § 4-315(a)(6).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the Maryland Dentistry Act, H.O. §§ 4-315(a)(6).

ORDER

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

ORDERED that the Respondent's license to practice dentistry in the State of Maryland is placed on **PROBATION** for a period of **EIGHTEEN (18) MONTHS** to commence from the date that this Order is executed by the Board, subject to the following terms and conditions:

1. The Respondent shall successfully complete within thirty (30) days from the effective date of this Consent Order a Board-approved course or tutorial in oral radiology;

2. The Respondent shall successfully complete within thirty (30) days from the effective date of this Consent Order a Board-approved course or tutorial in record keeping, focusing on documentation of patient charts;

3. The Respondent shall have a Board-approved clinical practice reviewer (the "reviewer") in general dentistry to monitor the Respondent's practice of dentistry as follows:

- a. The Respondent shall permit the reviewer to conduct unannounced random chart review of at least eight (8) patient charts, chosen from the Respondent's appointment calendar from the preceding three (3) month period, on a quarterly basis within the first year of probation, and once more at the conclusion of the probationary period, resulting in a total of five (5) reviews;

- b. The Respondent shall provide the reviewer with the complete record for each patient whose care is being reviewed, including radiographs. Production of the patient records to the reviewer shall be by overnight delivery or on-site review, as determined by the reviewer. The reviewer shall focus on the Respondent's documentation from the date when the Respondent completes the Board approved courses or tutorials forward. The reviewer will focus only on the Respondent's documentation and radiographic technique.
- c. The Respondent shall ensure that the reviewer submit written reports to the Board and the Respondent within fifteen (15) days of each review describing the reviewer's findings with respect to the Respondent's documentation and radiographic technique and making recommendations for improvement; and
- d. The Respondent shall comply with all written recommendations of the reviewer or the Board. Failure to comply with the written recommendations shall be deemed a violation of the Consent Order; 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 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 successfully complete the required courses within the required time period, fails to submit to the practice reviews, fails to cooperate with the practice reviewer, fails to follow the written recommendations of the practice reviewer or the Board, or that the Respondent's record keeping fails to meet appropriate standards, may constitute a violation of this Order and may, in the Board's discretion be grounds for further disciplinary action by the Board against the Respondent; 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 his probationary status without further restrictions only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including the expiration of the eighteen (18) month probationary period 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 this Order is a public document pursuant to Md. State Gov't Code Ann., §§ 10-611, *et seq.* (2009 Repl. Vol.)

4/21/10
Date


Jane S. Casper, R.D.H., M.A., President

CONSENT OF DONALD PARKER, D.D.S.

I, DONALD PARKER, D.D.S., License No. 4871, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with counsel, Catherine A. Hanrahan, Esq. before signing this document.
2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 4-318 (2009 Repl. Vol.) and Md. State Govt. Code Ann. §§ 10-201 *et seq.* (2009 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 provided by law. I am waiving those procedural and substantive protections.
4. I voluntarily enter into and consent to the foregoing Findings of Fact, Conclusions of Law and Order, and agree to abide by the terms and conditions set forth herein. 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 Govt. Code Ann. §§10-201 *et seq.* (2009 Repl. Vol.).
5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, and, following proper procedures, I may be subject to disciplinary action, which may include reprimand, suspension or revocation of my license to practice dentistry in the State of Maryland.

6. I sign this Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Order.

04/09/2010
Date

Donald Parker, D.D.S.
Donald Parker, D.D.S.

Catherine A. Hanrahan
Review and approved by:
Catherine A. Hanrahan, Esq.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF BALTIMORE

I HEREBY CERTIFY that on this 9th day of APRIL, 2010 before me a Notary Public of the foregoing State of Maryland and the City/County aforesaid, personally appeared Donald Parker, D.D.S., License Number 4871, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Simon V. Berkovitz
Notary Public

My Commission Expires: 10/07/2013