IN THE MATTER OF	*	**BEFORE THE**
MARK PITTS, D.D.S.	*	**STATE BOARD**
LICENSE No: 11347	*	**OF DENTAL EXAMINERS**
Respondent	*	**CASE NUMBER: 2009-071**

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ORDER FOR SUMMARY SUSPENSION

Based on information received by the Maryland State Board of Dental Examiners (the "Board") concerning the dental practice of **MARK PITTS, D.D.S.** ("Respondent"), license number 11347, the Board has reason as set forth below, to find that the public health, safety and welfare imperatively requires emergency action under Md. Code Ann., State Government ("State Gov't") § 10-226(c)(2) (2004 Repl. Vol.) and pursuant to the Maryland Dentistry Act (the "Act"), Md. Health Occupations ("Health Occ.") Code Ann. §§ 4-101 *et seq.* (2005 Repl. Vol. & Supp. 2007). The applicable section of S.G. § 10-226(c)(2) provides:

(c) *Revocation of* [sic] *suspension.* –

> (2) A unit may order summarily the suspension of a license if the unit:
>
> (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
>
> (ii) promptly gives the licensee:
>
> 1. written notice of the suspension, the finding and the reasons that support the finding; and
> 2. an opportunity to be heard.

This Order is based on the following investigative findings, which the Board has reason to believe are true:[1]

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[1] The statements regarding the Respondent's conduct are only intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not

FINDINGS OF FACT

1. The Respondent is licensed to practice dentistry in the State of Maryland under License Number 11347. The Respondent's license expires on June 30, 2009. The Respondent's specialty is oral maxillofacial surgery.

2. The Respondent operates a private oral surgery practice located at the Ballenger Creek Professional Center, 6550 Mercantile Drive East, Suite 101, Frederick, Maryland 21703.

3. On or about July 21, 2008, the Board received a complaint from a former employee ("Employee A") of the Respondent alleging standard of care issues, unprofessional conduct, and Centers for Disease Control ("CDC") violations.

4. As a result of the complaint, the Board opened an investigation into the allegations.

5. Employee A, who was employed by the Respondent from December 2007 until July 2008, stated that the Respondent has an uncontrolled medical condition, a seizure disorder, which places patients' health and safety at risk and interferes with the Respondent's oral surgery practice.

6. Specifically, Employee A stated that on multiple occasions, the Respondent experienced seizures while administering anesthesia, while a patient was under anesthesia and during patient consultations.

7. The Respondent is the only individual in the practice who is qualified to provide care and treatment to patients who are under anesthesia.

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necessarily represent a completed description of the evidence, either documentary or testimonial, to be offered against the Respondent in this matter.

However, on several occasions unqualified staff members were forced to take over the care of a patient under anesthesia when the Respondent experienced a seizure.[2]

8. The Respondent has informed his staff that he has a seizure disorder, describing to several staff members the origin of the condition.

9. On one occasion, Employee A witnessed the Respondent experience a seizure while he was starting an intravenous line ("IV") on a patient. The patient was being administered nitrous oxide. At the time, Employee A was not aware of the Respondent's seizure disorder, but realized that "something was wrong" and it lasted for "maybe 60 seconds or less." Employee A stated that Employee B, a longtime employee of the Respondent, was assisting the Respondent in starting the IV. Employee A stated that Employee B took the IV out of the Respondent's hand until the seizure passed. Employee B, who was interviewed separately by the Board's investigator, independently corroborated this incident. Employee B also stated that the patient's parent was sitting in the room, and Employee B was forced to take over for the Respondent by hooking up the IV and standing in front of the parent. Employee B stated that the parent was never aware of what was going on because she covered for the Respondent.

10. On a second occasion, Employee A recalled that the Respondent was in a consultation with a female patient when the patient ran out of the room to the front desk saying that something was wrong with the Respondent.

[2] In order to maintain confidentiality, the names of staff members are not contained in this Order but may be obtained by the Respondent by contacting the Administrative Prosecutor.

11. Employee A recalled a third incident in which the Respondent experienced a seizure in the middle of an extraction. Employee A recalled that the patient was under IV sedation when the Respondent "started speaking gibberish. . . behaving unusually [like he was] not present and attentive and himself," and instrumentation passing was not occurring properly. Employee A stated that the incident lasted "maybe 60 seconds" before the Respondent recovered from the episode.

12. Employee A also recalled that the Respondent spoke frequently about how his seizure medication made it difficult to think and made him feel groggy and tired. Employee B recalled the Respondent's complaints that his seizure medicine made him feel "funny."

13. Employee A stated that Respondent threatened her "affiliations with other people in the dental community" if she discussed his medical condition outside of the office. Employee B stated that the Respondent required all employees to sign a document to agree not to speak about anything outside the office. The document did not specify the prohibited subject matter, but Employee B believed it referred to the Respondent's seizure disorder.

14. Employee B, who was employed by the Respondent from June 1999 until June 2008, stated that every time the Respondent sedated a patient, she worried that he would have a seizure because she would have to "take over for about a minute, minute-and-a-half" until the seizure passed.

15. Employee B stated that she witnessed the Respondent having a seizure at work "a dozen or more times."

16. Employee B recalled another occasion when the Respondent experienced a seizure during a case, while holding a syringe. The patient had been placed on nitrous oxide for the procedure. Employee B mouthed to the other staff member, who was training, "he's having a seizure," and took the syringe from the Respondent's hand. Employee B told the patient to continue to breathe, "so the patient would not notice" what was going on with the Respondent.

17. Employee B also recalled two or three instances when the Respondent had a seizure during a patient consultation.

18. Employee B stated that when the Respondent recovers from a seizure, he is "very quiet, kind of disconnected, not quite remembering sometimes where he left off, and has to be told."

19. Employee B also recalled that there was a tacit agreement between office personnel not to inform patients about the Respondent's seizure disorder. The Respondent's wife, who is also the office manager of the practice, preferred to keep the situation confidential and downplayed the incident if a seizure occurred in front of a patient.

20. During her nine-year employment, Employee B recalled approximately a dozen occasions when the Respondent's wife told her that he had a seizure the night before and to carefully observe him because of her concern that he might have another seizure during the day.

21. Employee B expressed concern that the Respondent's uncontrolled seizure disorder placed patients in danger, especially if they were under any type

of anesthesia. Employee B worried about the Respondent having a seizure while a pediatric patient was under anesthesia because of the potential for breathing problems with the patient. As a result, Employee B always watched him very closely for any signs of a seizure.

22. Employee A stated that Respondent self-prescribed to treat his seizure disorder and used his DEA number to have Employee B order his medication from Southern Anesthesia & Surgical, a company that provides pharmaceuticals and surgery supplies to dental practices. Employee B confirmed that she ordered seizure medication for the Respondent from Southern Anesthesia & Surgical "several times."

23. The Board requested documentation of all controlled and uncontrolled drug purchases made by the Respondent from January 1, 2005 through December 31, 2008. The documentation revealed the following purchases:

Date	Medication & Dosage	Quantity
May 4, 2005	Carbamazepine 200 mg	12 bottles, 100 pills each
December 6, 2005	Carbamazepine 200 mg	12 bottles, 100 pills each
December 7, 2006	Carbamazepine 200 mg	12 bottles, 100 pills each

24. Carbamazepine (brand name: Tegretol) is indicated for use as an anticonvulsant in the treatment of seizure disorders. The primary reason to use Carbamazepine in an oral surgery office would be for the treatment of Trigeminal Neuralgia, a condition that causes facial pain or Temporomandibular Joint Disorder (TMJD), which causes tenderness and pain in the temporomandibular joint. However, the drug would typically be prescribed for the patient and not stocked and dispensed by the oral surgeon.

25. Finally, on November 20, 2008, the Board's Investigator made an unannounced inspection of the Respondent's office to determine compliance with the CDC guidelines on universal precautions.[3] Two CDC violations were observed. First, there were no dates on sterilized instrument bags. Second, it was discovered that spore testing was conducted twice monthly, rather than weekly.

26. The Board concludes that the Respondent has an uncontrolled medical condition that affects his ability to practice dentistry safely and places his patients at a substantial risk of harm.

INVESTIGATIVE CONCLUSIONS

Based on the foregoing investigative findings, the Board concludes that the public health, safety, and welfare imperatively requires emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2).

[3] The Centers for Disease Control ("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 and dentist's 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 sets 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.

ORDER

Based on the foregoing Investigative Findings and Conclusions, it is, by a quorum of the State Board of Dental Examiners, pursuant to the authority vested in the Board by Health Occ. § 4-315(a) and State Gov't § 10-226(c)(2), hereby:

ORDERED that the Respondent's license to practice dentistry in the State of Maryland is **SUMMARILY SUSPENDED**; and it is further **ORDERED** that, on presentation of this Order, the Respondent shall surrender to the Board Investigator the following items:

1) his original Maryland license number 11347;

2) the renewal card for his license to practice dentistry from the State Board of Dental Examiners;

3) DEA Certification of Registration;

4) Maryland Controlled Dangerous Substances Registration Certificate;

5) all controlled dangerous substances in his possession or practice;

6) all Medical Assistance prescription forms in his possession or practice;

7) any prescription pads on which his name and DEA number are imprinted; and it is further

ORDERED that during the period of **SUSPENSION**, the Respondent shall be prohibited from providing patient care and the Respondent shall post a conspicuous and securely attached notice on his office door or other obvious location which shall state in part:

1. That Dr. Pitts's dental practice shall be closed until further notice;

2. The name, address, and telephone number of at least one other local dentist who the Respondent has confirmed will be available to treat the Respondent's patients in the event of an emergency;

3. The name, address, and telephone number of the nearest hospital emergency room; and it is further

ORDERED that during the period of **SUSPENSION**, the Respondent shall maintain an active office telephone number that has a recorded message informing patients of the information contained in items 1-3 of the previous paragraph, or alternatively have a staff member available to provide the information to callers; and it is further

ORDERED that upon the request of the Respondent, made within ten (10) days of the service of this ORDER FOR SUMMARY SUSPENSION, a Show Cause Hearing will be scheduled within thirty (30) days of the request, for the Respondent to have the opportunity to show cause as to why his license should not continue to be suspended; and it is further

ORDERED that this **ORDER FOR SUMMARY SUSPENSION** is a **PUBLIC DOCUMENT** as defined in Md. State Gov't Code Ann. § 10-611 *et seq.* (2004).

02-10-2009
Date

John Timothy Modic, D.D.S.
President
Maryland State Board of Dental Examiners