IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MARVA J. HERRING, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 9986	*	**Case Number: 2007-091**

* * * * * * * * * * * *

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE DENTISTRY

Based on information received by the Maryland State Board of Dental Examiners (the "Board"), concerning the dental practice of MARVA J. HERRING, D.D.S. ("Respondent"), license number 9986, the Board has reasons as set forth below to find that the public health, safety and welfare imperatively requires emergency action under Md. State Gov't ("S.G") Code Ann. § 10-226(c)(2) (2004 & Supp. 2006) and pursuant to the Maryland Dentistry Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (2005 & Supp. 2006). The pertinent provisions of H.O. § 4-315(a), and those under which this Order is based, provide:

> (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:
>
> (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
>
> (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.

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.

INTRODUCTION

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, 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 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.

Based on a complaint, the Board visited and investigated the Respondent's dental office. The investigation, which is on-going, involved two visits to the office, interviews with the Respondent, observation of the clinical setting and obtaining documentation.

At the time of the office visits, no emergencies were occurring. The investigation revealed that despite the CDC guidelines, the Respondent's office was in complete disarray and that instruments were strewn about all over the office, some bagged and many un-bagged. Instruments were stored in that manner in drawers, cabinets, under the sink, in milk crates and on countertops. It was impossible to confirm if the instruments were sterile. The "sterilization area" was filthy dirty, contained tools for cutting floor tiles, had patient impressions and was otherwise in complete disarray. The Respondent treated at least one patient in this setting and indicated that she had treated others as well. The Respondent's actions allow for the potential transmission of the HIV virus, hepatitis B and C, tuberculosis and other similar bloodborne pathogens. Instead of reducing the likelihood of infection, the Respondent's actions may result in increasing exponentially the chance of infecting her patients and others. The inspection revealed numerous other CDC violations as well.

Because the Respondent fails to take proper precautions for disease control, and otherwise practices dentistry in an incompetent and unprofessional manner, as described more fully below, the Respondent presents an immediate danger to her patients and others. As a result, allowing the Respondent to continue to practice dentistry on patients in Maryland poses a grave risk of imminent danger to the public health, safety, and welfare of the citizens of the State of Maryland.

INVESTIGATIVE FINDINGS

Based upon the investigative information obtained by, received by, made known to, and available to the Board and the Office of the Attorney General, including the facts and details described below, the Board has reason to believe that the following facts are true:

1. At all times relevant hereto, the Respondent was and is a dentist licensed to practice dentistry in the State of Maryland initially receiving her license on August 25, 1988.

2. The Respondent practices dentistry in a residential condominium.

3. On or about October 3, 2006, the Board received a complaint alleging facts which, if true, would be violations of CDC guidelines. The complaint came from the management group of the condominium where the Respondent practices dentistry. The complaint alleged, *inter alia,* that no special waste management trucks were seen evidencing bio-hazardous waste pick-up and that a plumber advised them that the office was filthy and emitted a terrible odor. The Board referred the complaint to its investigative unit.

Office Visit, November 27, 2006

4. On or about November 27, 2006, Board investigators presented to the Respondent's office. The investigators did not observe the Respondent provide patient care on this date but a patient did appear at the office for an appointment and the Respondent turned him away. The Respondent indicated that she was seeing patients on an emergency basis.

5. The operatory used for patient care had a wall unit full of dental supplies, instruments and materials that were stored half-hazardously; some bagged and some un-bagged and open to contamination. Dental supplies and instruments were also stored under the sink in the operatory, again in a haphazard fashion; some bagged and some un-bagged and open to contamination. The area would be impossible to disinfect following patient care due to the extensive clutter on the exposed surfaces. The treatment area was not aseptic.

6. The "sterilization area" which is an area to be used to pre-clean and autoclave instruments was also used as an x-ray room and the lab. The sink in the room was overrun with models and impressions which showed no evidence of disinfection. The area evidenced co-mingling of clean and contaminated instruments, materials and armamentarium. The Respondent also had a tile cutter in the room which had apparently been recently used to cut floor tiles.

7. There was a kitchen in the office which was also heavily cluttered and had evidence of cockroach infestation.

8. Bio-hazardous waste was mixed with patient charts, administrative materials and other items which are impossible to disinfect. The sharps container was used as a stand holding a box of patient charts, lab materials and other items which cannot be disinfected.

9. The investigators observed an incubator used to incubate spores for spore testing the autoclave, however, the evidence provided by the Respondent to verify weekly spore testing appeared to be unreliable.

Office Visit, November 28, 2006

10. The investigators returned to the Respondent's office on November 28, 2006 in an effort to observe patient care. The Respondent indicated that she had treated a patient the previous day after the investigators left the premises. The Respondent did not treat any patients while the investigators were present.

Documentation

11. The documentation providing evidence of weekly spore testing is unreliable.

12. The documentation provided by the Respondent to evidence bio-hazardous waste removal was unreadable.

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)(2004 & Supp. 2006).

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 Md. Health Occ. Code Ann. § 4-315(a) and Md. State Gov't Code Ann. § 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) her original Maryland license number 9986;

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

3) DEA Certification of Registration number BH1643267;

4) Maryland Controlled Dangerous Substances Registration Certificate Number D29124;

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

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

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

ORDERED that a Show Cause Hearing date has been reserved for **Wednesday, January 17, 2007 at 12:00 p.m.** before the Board at the Board's offices, Spring Grove

Hospital Center, 55 Wade Avenue, Benjamin Rush Building, Catonsville, Maryland 21228, for the Respondent to have the opportunity to show cause as to why her license should not continue to be suspended, should the Respondent seek the hearing; and it is further

ORDERED that, if the Respondent intends to appear at the Show Cause Hearing on January 17, 2007, she must notify the Board, in writing, of her intent to appear and be heard. The Respondent's written intent to appear must be received in the Board's offices no later than Friday, January 12, 2007; and it is further

ORDERED that, if the Respondent's license remains suspended following the Show Cause Hearing, the Respondent can request an evidentiary hearing. The Respondent must request the hearing within thirty (30) days of the notice to continue the suspension. Unless timing is waived by the Respondent, the evidentiary hearing will be held either at the Board or at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031, within forty-five (45) days of the Respondent's request for such a hearing; and it is further

ORDERED that if a request for an evidentiary hearing is not received in the Board's offices within thirty (30) days of the notice to the Respondent of the intent to continue the suspension, the Respondent waives all rights now and in the future to any hearing with respect to this Order, or to any proceedings that would contest the validity of the findings of this Order for Summary Suspension, and it is further

ORDERED that this Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2004 & Supp. 2006).

1-3-07
Date

James P. Goldsmith, D.M.D.
President
Board of Dental Examiners