

IN THE MATTER OF
GORDON ZORN, D.D.S.
RESPONDENT

License Number: 6193

* BEFORE THE MARYLAND
* STATE BOARD OF
* DENTAL EXAMINERS
* Case Number: 2015-056

* * * * *

CONSENT ORDER

On or about April 15, 2017, the Maryland State Board of Dental Examiners (the "Board") charged **GORDON ZORN, D.D.S., License Number 6193** (the "Respondent"), with violations of the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. I §§ 4-101 *et seq.* (2014) and the regulations adopted by the Board, Md. Code Regs. ("COMAR") §§ 10.44.01 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of the Act:

§ 4-315. Denials, reprimand, probations, suspension, and revocations -- Grounds.

(a) *License to practice dentistry.* -- Subject to the hearing provisions of §4-318 of this subtitle, the Board may . . . reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the . . . licensee:

- (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
- (20) Violates any rule or regulation adopted by the Board;

The Board charges the Respondent with violating the following regulations adopted by the Board:

COMAR § 10.44.23.01 Unprofessional or Dishonorable Conduct

A. Definition.

- (1) In this regulation, the following term has the meanings indicated.
- (2) Term defined. "Legitimate patient" means a patient who has an existing written dental record or who has one created within 72 hours of the patient's first communication with the dentist.

E. It shall constitute unprofessional and dishonorable conduct for a dentist to:

- (2) Prescribe prescription medications for individuals who are not legitimate patients;
- (5) Treat family members or staff differently than any other patient by:
 - (a) Not maintaining accurate records of all treatment provided in accordance with COMAR 10.44.30, including:
 - (ii) Records of all medication prescribed;

COMAR § 10.44.30.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

B. Dental records shall include:

- (1) A patient's clinical chart as described in Regulation .03 of this chapter;

K. Dental records shall:

- (2) Be detailed;
- (5) Document all data in the dentist's possession pertaining to the patient's dental health status;

COMAR § 10.44.30.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

- (10) Identification of medications prescribed, administered, dispensed, quantity, and directions for use;

COMAR § 10.44.30.05 Violations

- A. Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

In order to resolve the case, the Board and the Respondent agreed to enter into this public Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds the following facts:

Mitigating Factors

Several mitigating factors are operative in this case, and weigh in the Board's decision to accept this Consent Order. These include but are not limited to the following. The Respondent has no prior record of Board discipline despite a career spanning several decades. Additionally, the Respondent himself notified the Board regarding prescription irregularities at his practice. Thus, the Respondent's own conscientious action caused the Board to initiate the investigation. Finally, the Respondent was unusually cooperative at all stages of the Board's investigation of this case.

Background

1. At all times relevant to the charges herein, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about July 8, 1976, under License Number 6193. The Respondent's license is renewed through June 30, 2017.

2. At all times relevant to these charges, the Respondent operated a dental practice at 17121 York Road, Parkton, MD 21120.

Background

3. On or about November 2, 2016, the Board issued a Final Order in a related case, Board case number 2013-193. The Final Order contained findings of fact regarding a former employee of the Respondent who was convicted of obtaining a controlled dangerous substance (CDS) by fraud.

4. In the course of investigating Board case number 2013-193, the Board's investigator conducted two interviews with the Respondent, on May 23, 2013 and again on August 5, 2014.

5. Based partly on the Respondent's statements in those interviews, the Board began an investigation into the Respondent's prescribing practices. Specifically, the Respondent stated that he had prescribed CDS to a former employee ("Patient A") and to Patient A's boyfriend at the time ("Patient B") even though he suspected that Patient A had been abusing narcotics. The Respondent also stated that he established the need for the prescriptions based on the patients' "word of mouth." In addition, the Respondent acknowledged that he had failed to record prescriptions in the patients' charts, despite being aware that failing to do so was improper.

Investigation

6. In furtherance of its investigation, on or about August 31, 2013¹, the Board requested from the Respondent the complete treatment records for Patients A and B and a narrative of treatment for each.

7. At approximately the same time, the Board requested prescription records from three area pharmacies ("Pharmacies A, B & C") for 2009 through 2012 for Patients A and B. The records received in response indicated that the Respondent had written multiple prescriptions for CDS for Patients A and B.

¹ On or about September 11, 2015, the Board issued a second subpoena for same. On September 15, 2015, the Respondent provided a copy of his response, dated August 21, 2013, to the original subpoena. It appears that this response had been misfiled or misplaced by a previous Board investigator.

8. On or about August 8, 2014, in furtherance of the investigation, the Board's investigator requested the Respondent's prescribing history from the Alcohol and Drug Abuse Administration (ADAA), which collects this information through the Maryland Prescription Drug Monitoring Program (PDMP). In response, the ADAA provided the Respondent's prescriber history (the "PDMP Report") and the report of the ADAA's Technical Advisory Committee (TAC) regarding the Respondent's prescribing history (the "TAC Report")².

9. On or about October 7, 2014, the Board requested from the Respondent the treatment records of five (5) additional individuals to whom the Respondent had prescribed CDS according to the PDMP Report and the TAC Report ("Patients C, D, E, F & G").

10. The Board referred the treatment records of Patients A through G to an expert in general dentistry (the "Expert") for a review of the Respondent's care. On or about December 15, 2015, the Expert issued a report (the "Expert Report") of his findings. The prescribing records and the Expert Report revealed the following.

Patient A

11. Patient A's clinical chart comprises approximately seven (7) entries, from December 5, 2005 until January 16, 2008. However, the records also indicate that an anterior bite plate was placed for Patient A on June 22, 2009. There is no note in Patient A's chart reflecting this treatment. In addition, the Respondent stated in his narrative that he treated Patient A thereafter for routine cleanings an unspecified number of times. There are no notes in Patient A's chart reflecting these treatments.

² The PDMP tracks prescriptions: (1) of CDS, (2) dispensed in Maryland, and (3) after August 20, 2013. Based on these limitations, the information contained in PDMP and TAC Reports does not necessarily reflect the Respondent's full prescribing history.

12. The records obtained from Pharmacies A, B & C indicate that from 2009 through 2012, the Respondent wrote at least 25 (twenty-five) prescriptions for CDS to Patient A. However, the Respondent failed to record any of these prescriptions in Patient A's clinical chart.

13. According to the Expert Report, given the lack of documentation for these CDS prescriptions for Patient A, there is no justification for the prescriptions.

Patient B

14. Patient B's clinical chart comprises eight approximately eleven (11) entries, from January 19, 2005 until July 25, 2011.

15. The records obtained from Pharmacies A, B & C indicate that from 2009 through 2012, the Respondent wrote at least nine (9) prescriptions for CDS to Patient B. However, the Respondent failed to record at least eight (8) of these prescriptions in Patient B's clinical chart.

16. According to the Expert Report, given the lack of documentation of these CDS prescriptions for Patient B, there is no justification for these eight (8) prescriptions.

Additional Patients

Patient C

17. The Respondent's narrative statements, dated October 16, 2014 and October 31, 2014, offer a summary of his treatment of Patient C.

18. In these statements, the Respondent acknowledged that he had prescribed antibiotics and "pain medication" to Patient C. However, the Respondent never created a dental record for Patient C because he never examined Patient C. The Respondent based his prescriptions on a telephone conversation with Patient C and a conversation with Patient C's spouse. The Respondent explained that Patient C's

spouse was the Respondent's dental assistant, and his policy is to "offer a generous dental benefit to whoever works for me and their immediate family."

19. According to the PDMP Report and the TAC Report, during 2013 and 2014, the Respondent wrote at least three (3) prescriptions for CDS to Patient C. However, the Respondent failed to make any record of these prescriptions.

20. According to the Expert Report, given the lack of any treatment record for Patient C, there is no justification for any of the prescriptions.

Patient D

21. Patient D's clinical chart comprises approximately five (5) entries, from April 10, 2014 until June 11, 2014, documenting two (2) visits. Patient D's records include blank initial examination and periodontal examination sheets. There is no documented examination intra or extra oral examination and no medical history.

22. According to the PDMP Report and the TAC Report, during 2013 and 2014, the Respondent wrote at least four (4) prescriptions for CDS to Patient D. However, the Respondent failed to make any record of these prescriptions.

23. According to the Expert Report, given the lack of documentation for these CDS prescriptions for Patient D, there is no justification for any of the prescriptions.

Patient E

24. Patient E's clinical chart comprises approximately one (1) entry, on September 25, 2013, documenting a cancelled visit. Patient E's records include blank initial examination and periodontal examination sheets. There is no oral diagnosis or examination noted.

25. In addition, Patient E's records contain a notice, dated June 27, 2014, from Patient E's insurance company flagging a pattern of Patient E filling prescriptions that "may indicate abuse potential or inappropriate use of opioids."

26. According to the PDMP Report and the TAC Report, during 2013 and 2014, the Respondent wrote at least 31 (thirty-one) prescriptions for CDS to Patient E. However, the Respondent failed to make any record of any of these prescriptions.

27. According to the Expert Report, given the lack of documentation for these CDS prescriptions for Patient E, there is no justification for any of the prescriptions.

Patient F

28. Patient F's clinical chart comprises approximately six (6) entries, from December 14, 2005 to March 17, 2014, documenting five (5) visits. Patient F's records include very limited documentation throughout the chart and no medical forms. There is no oral cancer screening, no head and neck examination, no medical history review, no periodontal charting, no oral diagnosis, and no oral conditions noted.

29. According to the PDMP Report and the TAC Report, during 2013 and 2014, the Respondent wrote at least fourteen (14) prescriptions for CDS to Patient F. However, the Respondent failed to make a record of at least thirteen (13) of these prescriptions.

30. According to the Expert Report, given the lack of documentation for these CDS prescriptions for Patient F, there is no justification for any of the prescriptions.

Patient G

31. Patient G's clinical chart documents multiple visits from February 12, 1999 to April 24, 2014. Patient F's records include very limited documentation throughout.

32. In addition, Patient G's records contain a notice, dated February 4, 2014, from Patient G's insurance company flagging a pattern of Patient G filling prescriptions that "may indicate abuse potential or inappropriate use of opioids."

33. According to the PDMP Report and the TAC Report, during 2013 and 2014, the Respondent wrote at least eight (8) prescriptions for CDS to Patient G. However, the Respondent failed to make a record of at least five (5) of these prescriptions.

34. According to the Expert Report, given the lack of documentation for these CDS prescriptions for Patient G, there is no justification for any of the prescriptions.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the Act and the regulations adopted by the Board as cited above.

Specifically, the Respondent's actions, as described above, including prescribing CDS without justification, and failure to properly document CDS prescriptions, constitute violations of regulations cited and the following provisions of the Act, specifically: Health Occ. I § 4-315(a): (16) Behaves dishonorably or unprofessionally or violates a professional code of ethics pertaining to the dentistry profession; and (20) Violates any rule or regulation adopted by the Board; and the regulations adopted by the Board, as cited above.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by the Board, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is **FINED** in the amount of \$5000, of which \$2500 is stayed pending compliance with this Consent Order³, leaving **\$2500 PAYABLE TO THE BOARD WITHIN THIRTY (30) DAYS** of the effective date of this Consent Order; and it is further

ORDERED that the Respondent shall hereafter limit his prescribing of CDS pain medication to the immediate period of recovery following treatment, not to exceed seven (7) days;

ORDERED that the Respondent shall be placed on **PROBATION** for a period of no less than **TWENTY-FOUR (24) MONTHS**, to commence on the effective date of this Consent Order, and continuing until the Respondent successfully completes the following probationary conditions:

1. Within ninety (90) days of the effective date of this Consent Order, the Respondent shall engage the services of a Board-approved supervisor, who shall act as a mentor, with particular focus on prescribing and documentation. The Respondent shall meet in person with the supervisor at least once per month during the period of probation to review treatment practices. The Supervisor shall provide the Board with written reports at least once every six (6) months during the period of probation;
2. Within six (6) months of the effective date of this Consent Order, the Respondent shall, at his own expense, successfully complete a course, approved by the Board in advance, equivalent to at least six (6) continuing education (C.E.) credits, focusing on proper CDS prescribing practices. The Respondent shall successfully complete the course as scheduled, and shall submit written verification that satisfies the Board of his successful completion within 30 days of completion of the course;
3. Within six (6) months of the effective date of this Consent Order, the Respondent shall, at his own expense, successfully complete a course, approved by the Board in

³ If the Respondent successfully completes the probationary conditions of this Consent Order, the stayed portion of the fine, \$2500, shall be dismissed upon the Board's termination of probation.

advance, equivalent to at least six (6) continuing education (C.E.) credits, focusing on dental recordkeeping. The Respondent shall successfully complete the course as scheduled, and shall submit written verification that satisfies the Board of his successful completion within 30 days of completion of the course;

4. At its discretion, during the probationary period, the Board may conduct up to three (3) record reviews of the Respondent's patient records. Each record review shall be conducted by a Board-designated expert who shall review the records of a selection of patients whom the Respondent has treated. The Board designee may personally select the records of the patients on site at the Respondent's practice, and may do so at either a scheduled or unannounced visit. In order to facilitate the Board designee's ability to access the Respondent's patient records, the Respondent shall, on the first of each month, provide the Board with a copy of his appointment book. If the Respondent will not be present at the office during these appointment times, he shall notify the Board beforehand, unless he is unable to do so by reason of a documented emergency or illness.
5. Within thirty (30) days of the effective date of this Consent Order, the Respondent shall register with the Maryland Prescription Drug Monitoring Program (PDMP);

and it is further

ORDERED that no part of the training or education that the Respondent receives in order to comply with this Consent Order may be applied to his required continuing education credits, and the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that the Respondent shall comply with the Act; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, and any of its agents or employees, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

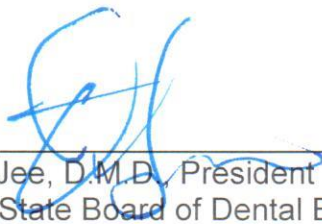
ORDERED that the Respondent shall be responsible for all costs incurred under

this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or an evidentiary hearing if there is a genuine dispute of fact, may impose an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that this Consent Order is a Final Order of the Board and a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

7/19/17
Date


Arthur C. Jee, D.M.D., President
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Gordon Zorn, D.D.S., acknowledge that I have had the opportunity to consult with legal counsel at all stages of this matter. I understand that this Consent Order will resolve the Charges against me and forfeit my right to a formal evidentiary hearing on the Charges. By this Consent, I agree to be bound by the terms of this Consent Order. I acknowledge under oath that I in fact committed the specific violations as set forth above. I acknowledge under oath the accuracy of the Findings of Fact and the validity of the Conclusions of Law contained in this Consent Order. I acknowledge that for all purposes, the Findings of Fact and Conclusions of Law will be treated as if proven in 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 the law. I agree to

forego my opportunity to challenge these Findings of Fact and Conclusions of Law. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I waive my right to any appeal in this matter. I affirm that I have asked and received satisfactory answers to all my questions regarding the language, meaning, and terms of this Consent Order. I sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning, and terms of this Consent Order.

6/30/17
Date

Gordon Zorn, D.D.S.
The Respondent

Approved by:

6/30/17
Date

Henry Myerberg, Esq.
Counsel for the Respondent

NOTARY

STATE OF Maryland
CITY/COUNTY OF: Baltimore

I HEREBY CERTIFY that on this 30th day of June, 2017, before me, a Notary Public of the State and County aforesaid, personally appeared Gordon Zorn, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.



Notary Public

My commission expires: 5-17-20

