IN THE MATTER OF	*	BEFORE THE
HAROLD L. GOLDBERG, D.D.S.	*	STATE BOARD OF
License No. 2524	*	DENTAL EXAMINERS
Respondent	*	Case No. 2000-120

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

AMENDED ORDER FOR SUMMARY SUSPENSION

On March 6, 2000, the Maryland State Board of Dental Examiners ("the Board") hereby summarily suspends the license to practice dentistry of Harold I. Goldberg, D.D.S. ("Respondent"), License Number 2524, pursuant to the Maryland Dentistry Act ("the Act"), codified at Md. Code Ann., Health Occ. ("HO") §§ 4-101 et seq. (1994 Repl. Vol. and 1999 Supp.), and Md. Code Ann., State Gov't ("SG") § 10-226(c)(2) (1999 Repl. Vol.). On March 15, 2000, the Board voted to issue this Amended Order for Summary Suspension.

The pertinent provisions of HO § 4-315(a), and those under which the allegations which formed the basis of the Summary Suspension, are as follows:

> (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:
>
> > (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner; [or]
> >
> > (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 SG § 10-226(c)(2) provides that:

> (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 that detail the procedures deemed necessary to minimize the chance of infection, both from one patient to another, and from the dentist's staff to the patient. These guidelines include some very basic precautions, such as washing hands between patients, and also set forth more involved standards for infection control Under the Act, all dentists are required to comply with the CDC guidelines. The only exception to this rule arises in an emergency situation that is life-threatening and where it is not feasible or practicable to comply with the guidelines.

Based on a complaint, the Board conducted an CDC inspection of the Respondent's office on March 2, 2000. The investigation involved an examination of the office, observations of the Respondent's CDC practices, and an interview with the Respondent. There was no emergency at the time of the inspection. The investigation revealed that, despite the CDC guidelines, the Respondent, *inter alia*, was not wearing gloves or a mask while treating a patient when the Board's investigator arrived to conduct the inspection, did not wash his hands before putting on gloves, put a glove on his left hand while leaving the

right hand bare and unwashed, continued treating a patient without washing his hands or replacing his gloves despite having answered a telephone call, using a pen, and sorting through paperwork, failed to have protective covers on required surfaces and apparatus, failed to appropriately dispose of medical waste, failed to label bio-hazardous materials, and failed to provide spore testing for his Dry Heat Machine. The investigation revealed other CDC violations, as well.

The Respondent's failure, as described above, to comply with CDC guidelines exponentially increases the probability of infecting his patients, instead of reducing the likelihood of cross-contamination as is the intention of the CDC guidelines.

Because the Respondent fails to comply with CDC guidelines in the manner that he does, he is putting his patients at risk. By the Respondent's failure to comply with CDC guidelines as further detailed below, the Respondent presents an immediate danger to his patients. As a result, allowing the Respondent to continue to practice dentistry on patients in Maryland poses a grave risk and imminent danger to the public health, safety, and welfare of the citizens of Maryland.

ALLEGATIONS OF FACT

The charges are based upon the following facts, which the Board has cause to believe are true:

1. The Respondent is, and at all times relevant hereto was, licensed to practice dentistry in the State of Maryland under License Number 2524. The Respondent has no employees.

2. Subsequent to a complaint, the Board caused a CDC inspection of the

Respondent's dental practice located at 7501 Liberty Road, Baltimore, Maryland, to be made on March 2, 2000. The inspection was made by two members of the Board staff, both of whom are trained in conducting CDC inspections.

3. The purpose of the inspection was to determine whether the Respondent was complying with the CDC guidelines for infection control. A copy of those guidelines is attached hereto.

4. The inspectors inspected the Respondent's office and operatory and observed his treatment of one patient.

5. The inspectors arrived at the Respondent's office at 9:20 a.m., on March 2, 2000. Upon arrival at the Respondent's office the inspectors observed the Respondent with a patient, who was in the dental chair. The Respondent was not wearing gloves or a mask.

6. After a brief discussion with the investigators, the Respondent re-entered the operatory and returned to the patient. The Respondent did not wash his hands or place gloves on his hands prior to resuming patient care. The Respondent was providing care to the patient using rusty instruments, without gloves, without a mask or other facial shield and while wearing glasses without side shields.

7. Shortly after resuming patient care, the Respondent again exited the operatory, and obtained a pair of latex gloves and a mask from the bottom drawer of his desk. However, the Respondent did not wash his hands prior to putting on the gloves, and the Respondent only put a glove on his left hand. The Respondent's right hand remained unwashed and bare while treating the patient. The Respondent wore the mask

around his neck at all times, rather that placing it over his face.

8. The Respondent did not wash his hands or change his gloves when he returned to treating the patient after answering a telephone call, using a pen, and sorting through paperwork on his desk.

9. After the patient left the Respondent's office, the Respondent did not wash his hands.

10. The Respondent had no record of his hepatitis B vaccine in the office, explaining that he received vaccination approximately 12 to 15 years ago and that the physician who inoculated him has since deceased.

11. The Respondent did not have protective covers on the required surfaces in the operatory. In addition, the inspectors observed dry blood spattered on the overhead light and other equipment in the operatory. Other surfaces in the operatory were dusty, dirty and clearly had not been disinfected for an extended period of time.

12. The Respondent did not dispose of his contaminated waste in appropriate bags. The Respondent advised that he places used needles, after breaking the needle in an old metal paint can located in a cabinet. The paint can was observed to be in a non-readily accessible area, was not labeled as bio-hazardous, was not closed or capped and was not maintained in an upright position.

13. The Respondent indicated that he does sterilize his instruments via dry heat. The Respondent was unable to state at what temperature or for how long the machine specifications required for appropriate sterilization. The Respondent does not provide spore testing for his Dry Heat machine, and has never had a contract with a company to

do so. The Respondent advised the inspectors that he was unaware of this requirement. The Respondent told the inspectors that he cleans the instruments with soap and water, places them in a plastic bag for instruments, and then places them in the dry heat machine.

14. The inspectors observed several drawers full of old, rusty instruments, as well as rust on the instruments that had just been used on a patient, which were lying on a preparation tray at the foot of the chair. In addition, an inspection of the office and operatory revealed that the Respondent had metal trays hanging on the wall, including some that were still covered with old wax and dust. The office and operatory were in complete disarray as evidenced by dirt, dust, and objects that were exposed, dirty, and unpackaged.

CONCLUSIONS OF LAW

Based on the foregoing investigative information, the Board finds that the public health, safety, and welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (1999 Repl. Vol.).

PROCEDURAL HISTORY

The Board issued a prior Order for Summary Suspension on March 3, 2000 and the Respondent was served with that Order on March 6, 2000. On March 15, 2000, the Board voted to issue this Amended Order for Summary Suspension which replaces the Board's March 3, 2000 Order.

ORDER

It is, by a quorum of the State Board of Dental Examiners pursuant to the authority

vested in the Board by Md. Code Ann., Health Occ. §§ 4-205(a)(6) and 4-315(a), and Md. Code Ann., State Gov't § 10-226(c)(2),

ORDERED that the ORDER FOR SUMMARY SUSPENSION of March 3, 2000 is hereby amended as set out in this Order and that the March 3, 2000 Order shall not be reported to the National Practitioner's Data Bank; and it is further

ORDERED the Respondent's license to practice dentistry in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that the Respondent will be given an opportunity to Show Cause why his license should not be suspended at his previously scheduled Show Cause Hearing on **March 15, 2000, at 9:00 a.m.** before the Board at the Spring Grove Hospital Center, Tulip Drive, Benjamin Rush Building, Catonsville, Maryland 21228; and it is further

ORDERED that, if the Respondent's license remains suspended following a Show Cause Hearing, upon request by the Respondent, a hearing to consider this Summary Suspension will be held at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031, within a reasonably prompt time after the Respondent's request for such a hearing, and it is further

ORDERED that this Order is a public document pursuant to Md. Code Ann., State Gov't § 10-601 *et seq.* (1999 Repl. Vol.).

3-15-00
Date

Kathleen Geipe, D.D.S.
Board President