STATE OF WASHINGTON
DEPARTMENT OF HEALTH
DENTAL QUALITY ASSURANCE COMMISSION

In the Matter of: ALIREZA PANAHPOUR, Credential No. DENT.DE.60101476, Respondent.	Master Case No. M2017-927 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Alireza Panahpour, the Respondent, by
Seattle Litigation Group, PLLC, per
Jessica Creager, Attorney at Law

Department of Health Dental Program (Department), by
Office of the Attorney General, per
Alan C. Anderson, Assistant Attorney General

PANEL: Robert Shaw, DMD, Chair
Jim Henderson, Public Member
Bree Kramer, EFDA

PRESIDING OFFICER: John F. Kuntz, Review Judge

A hearing was held in this matter on April 11, 2019, regarding allegations of unprofessional conduct. Credential revoked; conditions required prior to re-licensure.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(4)?

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of: John Evans, DDS; and Ricney Newhouse, DMD. The Respondent testified and did not call any additional witnesses.

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: Credential View Screen for the Respondent (Updated Copy).

Exhibit D-2: Complaint filed with the Department of Health (DOH), dated December 7, 2016.

Exhibit D-3: Patient A records received from Complainant.

Exhibit D-4: Letter of Cooperation (LOC) to the Respondent, dated January 11, 2017.

Exhibit D-5: The Respondent's statement, dated March 20, 2017, in response to LOC.

Exhibit D-6: Exhibit A to the Respondent's statement, dated March 20, 2017.

Exhibit D-7: Exhibit B to the Respondent's statement, dated March 20, 2017.

Exhibit D-8: Exhibit C to the Respondent's statement, dated March 20, 2017.

Exhibit D-10: Exhibit E to the Respondent's statement, dated March 20, 2017.

Exhibit D-11: Exhibit F to the Respondent's statement, dated March 20, 2017.

Exhibit D-12: Exhibit G to the Respondent's statement, dated March 20, 2017.

Exhibit D-13: Exhibit H to the Respondent's statement, dated March 20, 2017.

Exhibit D-14: Exhibit I to the Respondent's statement, dated March 20, 2017.

Exhibit D-15: Exhibit J to the Respondent's statement, dated March 20, 2017.

Exhibit D-16: Patient A's x-rays received from the Respondent.

Exhibit D-17: Statement of John Evans, DDS, dated June 26, 2017.

Exhibit D-18: Patient A's records received from John Evans, DDS.

Exhibit D-19: Patient A's x-ray received from John Evans, DDS.

Exhibit D-20: Statement of Thomas Seal, DDS, dated March 15, 2017.

Exhibit D-21: Patient A's records received from Thomas Seal, DDS.

Exhibit D-22: Patient A's x-rays received from Thomas Seal, DDS.

Exhibit D-23: Patient A's x-rays received from Thomas Seal, DDS.

Exhibit D-24: Record for Patient A that were received from Dietrich Klinghardt, M.D.

Exhibit D-25: Copy of the Respondent's Disclaimer provided to patients.

Exhibit D-26: Printouts from the Respondent's website systemicdentisist.com.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-1: CV of Alireza Panahpour, DDS (19 pgs.).

Exhibit R-2: June 2017 email exchange between the Respondent and Patient A (1 pg.).

Exhibit R-3: June 2012 email from Patient A to provider (1 pg.).

Exhibit R-4: The Respondent's Clinical Notes of Patient A (9 pgs.).

Exhibit R-5: The Respondent's Operative Reports of Patient A (7 pgs.).

Exhibit R-6: June 14, 2016 letter to the Respondent from the Commission (1 pg.).

Exhibit R-7: Timeline for Case 2015-2443 (2 pgs.).

Exhibit R-8: Excerpt from Dr. Klinghardt's September 25, 2015 deposition (10 pgs.). A complete copy of the deposition was made available to the Commission panel at hearing.

Exhibit R-9: Declaration of Thomas H. Seal, DDS, that including Dr. Seal's medical and billing records for Patient A (8 pgs.).

Exhibit R-12: Complaint Form filed with DOH dated December 7, 2016, redacted except for Patient A's signature.

The parties requested the Presiding Officer provide a curative instruction to the Commission hearing panel. *See* Prehearing Order No. 4, dated March 5, 2019. On March 16, 2019, the parties submitted their proposed curative instruction to the Presiding Officer. The following instruction was read to the Commission panel at the hearing:

> Some of the evidence and witnesses introduced in this matter comes out of King County Superior Court case no. 15-2-03839-7SEA ["Superior Court Matter"], in which Patient A brought a civil suit against the Respondent. The Panel will not know the procedural history or outcome in that matter during the hearing on the merits, as the burden of proof in the Superior Court Matter was lower than what is required in this matter.
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> Any evidence concerning the lawsuit [will] not be considered in assessing whether the Respondent committed any negligence under the clear and convincing standard applicable in these proceedings. Any such evidence may only be considered for other purposes, such as possible sanctions (limited to whether refund or restitution could be made), motive, bias, and to explain certain conduct of the patient and Respondent.

At the conclusion of the hearing, the Department submitted exhibits to address the dental cost recovery issue, and a 2006 Stipulated Settlement and Disciplinary Order

from the Dental Board of California for consideration on the issue of sanctions. The Department also submitted a victim impact statement from Patient A.

I. FINDINGS OF FACT

1.1 The state of Washington granted the Respondent a license to practice as a dentist on November 3, 2009. The Respondent's license was active at all times during his treatment of Patient A.

1.2 Patient A suffered from a long-standing digestive problem. She sought a variety of treatment modalities, including alternative medical treatment modalities, to resolve her digestive problem.[1] In addition to naturopathic treatment, Patient A sought treatment from Dietrich Klinghardt, M.D. He ordered dental x-rays as a part of his diagnostic workup. Dr. Klinghardt believed the x-rays showed some red, hot, tender and painful areas in the right side of Patient A's jaw.[2] He further analyzed the x-rays using an ultraviolet light and felt Patient A might have issues on the left side as well.[3] Dr. Klinghardt's examination focused on the sites from Patient A's previously extracted four wisdom teeth, which were extracted approximately ten years earlier. Dr. Klinghardt thought Patient A might be experiencing some osteonecrotic areas in her jaw at those sites that required removal.[4] Relying on his x-ray analysis, Dr. Klinghardt referred her to the Respondent for further examination.

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[1] *See* Exhibit D-24, page 27 of 93. The Department's exhibits are identified by both investigative and exhibit numbers. The Commission will use the page numbers directly under the exhibit number on the lower right corner of the page.

[2] Exhibit R-8, page 29, of the September 25, 2015 Deposition of Dr. Klinghardt, lines 1-9.

[3] Exhibit R-8, page 34, of the September 25, 2015 Deposition of Dr. Klinghardt, lines 15-25.

[4] Exhibit R-8, page 33, of the September 25, 2015 Deposition of Dr. Klinghardt, lines 4-8.

1.3 On March 13, 2012, the Respondent conducted his initial examination of Patient A. His treatment notes from that initial examination indicated that Patient A "complains of possible focal infections in the jaw, which due to her research and doctors' input are responsible for her systemic challenges".[5] Patient A related that she was experiencing numbness in her lower right and lower left jaw line. At this point the Respondent should have performed, but failed to perform, any object tests to establish a baseline regarding the severity or extent of Patient A's reported numbness. The Respondent also did not refer Patient A to a board-certified dental surgeon to determine the cause of Patient A's complaints of numbness prior to performing the cavitation surgery for Patient A. The dental standard of practice requires taking such actions before performing surgery. Doing so would determine whether Patient A's complaints of numbness were indicative of nerve damage. Patient A's complaints might have indicated nerve damage in need of repair. The Respondent should have determined the severity or extent of any nerve injury before attempting any surgery. Unfortunately, the Respondent did not take these appropriate steps prior to going forward with the cavitation surgery here.

1.4 The Respondent initially created handwritten records for Patient A in 2012.[6] The copies provided were not legible. In fact, the Respondent had difficulty reading his own handwritten records at the hearing. So it was unclear what information, if any, the Respondent recorded regarding Patient A's complaints of numbness. He

[5] Exhibit D-3, page 3 of 47.

[6] Exhibit D-8, pages 1 through 8. Copies provided were less than readable.

eventually migrated Patient A's written records into an electronic patient record system in 2014.[7] The Respondent remembers adding information to the electronic records; but, he denies any substantive alterations were made when the handwritten records were migrated to the electronic format. Given the inability to read his own handwritten records, it was difficult to determine if the Respondent's earlier handwritten records confirm the information recorded in the later electronic version of the records.

1.5 The Respondent viewed a panoramic x-ray Patient A brought to the first appointment. However she chose not to leave them in the Respondent's possession. The Respondent took additional x-rays at Patient A's initial visit.[8] The Respondent's treatment plan for Patient A consisted of a procedure known as cavitation surgery, which consists of using a currette (a spoon shaped scraping instrument) to remove necrotic tissue from around a tooth.[9] Cavitation surgery is not generally accepted within the dental community as there is no good peer review, evidence-based studies that support the effectiveness of performing the procedure.

1.6 Aside from not being a generally accepted dental procedure, there was no objective indication to support the Respondent's decision to perform the cavitation surgery procedure for Patient A. Her four wisdom teeth were extracted approximately ten years earlier. Despite Dr. Klinghardt's x-ray analysis and the recommendations

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[7] Exhibit D-6, pages 2 and 3.

[8] For illustration purposes, *see* Exhibit D-19 (the panoramic x-ray from Dr. Seal); Exhibit D-16, pages 1 through 4 (the x-rays taken by the Respondent).

[9] *See* Taber's Cyclopedic Medical Dictionary, 21st Edition, page 557 (relying on the definition of "curettage").

from Patient A's naturopathic physicians, there were no objective indications that Patient A was suffering from osteomyelitis (inflammation of bone and marrow, usually caused by infection) at the sites of her previously extracted four wisdom teeth. She was not suffering from pain, had no puss or other discharge at the extraction sites, and was not experiencing any fever or swelling at the time of her treatment by the Respondent.

1.7 In fact, the Respondent decided to perform the cavitation surgery procedures in the absence of any indication of osteomyelitis or other dental issues at the sites of Patient A's previously extracted wisdom teeth. Rather he performed the cavitation surgery procedures to resolve Patient A's long-standing digestive and systemic issues. While he should have considered Patient A's complaints as a part of his evaluation, the Respondent should not have allowed her complaints to control what dental care was appropriate under the circumstances. Here the Respondent inappropriately relied on: (1) Patient A's request for the surgery; (2) the recommendations from Patient A's naturopathic physician regarding whether dental surgery would successfully address Patient A's digestive complaints; and (3) Dr. Klinghardt's x-ray examination findings regarding Patient A's jaw. The Respondent's decision shows he failed to exercise his own professional judgment regarding the required dental care. Despite any objective findings supporting the need for dental treatment, the Respondent chose to perform the cavitation surgery procedures based on Patient A's request and the opinions of other non-dental health care providers. Doing so did not meet the standard of care in Washington.

1.8 The Respondent performed Patient A's first cavitation surgical procedure on June 19, 2012, to address Patient A's lower right socket site. This surgery was uneventful. The Respondent sent a pathology sample to the Oral Pathology Group in Indianapolis, Indiana for review. The pathology report diagnosis was "lower right mandible, dense viable bone with fibro-fatty marrow exhibiting hemorrhage and marrow fibrosis".[10] The pathologist found this to be compatible with a diagnosis of chronic fibrosing osteomyelitis.

1.9 Patient A did not take any pain medication following the surgery, as she reportedly experienced no pain as a result of the procedure. However, she did report that the stomach issues and pain went away.[11] When her sutures were removed, Patient A reported her appendix pain went away, as well as the pain and discomfort she previously experienced on the lower left side of her jaw and shifted to the lower right side. Patient A requested the Respondent schedule the surgeries for the remaining sites.

1.10 The Respondent performed Patient A's second cavitation surgical procedure on July 17, 2012, to address Patient A's upper right socket site. This procedure was also uneventful. The Respondent sent a pathology sample from this procedure to the Oral Pathology Group for review. The pathology report diagnosis was "dense viable bone with fibrofatty marrow exhibiting hemorrhage and marrow fibrosis

[10] Exhibit R-5, page 7 of 7.

[11] Exhibit D-3, page 6 of 47.

with follicular connective tissue and oral (crevicular) mucosa".[12] The pathologist found this to be compatible with a diagnosis of chronic fibrosing osteomyelitis. Patient A again reported that she experienced no pain and felt full of energy. While the Respondent suggested she wait a few months before undergoing the next surgery, Patient A did not want to wait. This was another time when the Respondent should have exercised, but did not exercise, his own independent judgment regarding the timing of the treatment. He merely acceded to Patient A's request.

1.11 The Respondent performed Patient A's third cavitation surgery on July 31, 2012, to address Patient A's lower left socket site. The Respondent's treatment notes indicate that he curettage a large amount of diseased bone during this procedure from this site. Patient A had problems getting numb during this procedure, which the Respondent attributed to Patient A's earlier reported nerve damage. The Respondent stated that he gave her more procaine to achieve numbness. Unlike the other procedures, Patient A reported she was in extensive pain during this surgery.[13] That the Respondent transected the nerve was subsequently confirmed by Dr. Evan's review of the glass slide that was produced from the Respondent's pathology sample. Dr. Evans observed nerve tissue in the sample indicating that the Respondent transected Patient A's left inferior alveolar nerve.

1.12 The Respondent reported that he again sent a pathology sample from this procedure to the Oral Pathology Group for review. It read "mandible area of tooth #17

[12] Exhibit R-5, page 6 of 7.

[13] See Exhibit D-18, page 1 of 2.

and 18, mandible, extraction site of tooth #18, dense viable bone with fibro-fatty marrow exhibiting hemorrhage and marrow fibrosis".[14] The pathologist found this to be compatible with a diagnosis of chronic fibrosing osteomyelitis. While the pathologist's report did not reflect the information contained in the glass slide that accompanied the Respondent's pathology sample, Dr. Evans clearly remembers viewing the slide and seeing the nerve tissue in the Respondent's pathology sample.[15]

1.13 That the Respondent transected the nerve is further supported by his August 2, 2012, treatment note for Patient A. She reported to the Respondent that she was experiencing tingling on her chin area. Having failed to create a baseline reading at the beginning of Patient A's treatment, the Respondent should have created and recorded a baseline reading of the severity and extent of Patient A's complaints of numbness here. This would have allowed him to monitor Patient A's improvement or lack of improvement regarding the numbness issue at this point. Why was this important? Where, as here, the Respondent transected Patient A's lower left alveolar nerve, there is a limited window of time in which nerve injury repair can be addressed. This window of time is six to 12 months following the injury. After that no repair can be successfully achieved.

1.14 The Respondent performed Patient A's fourth and final cavitation surgery on August 14, 2012, to address Patient A's upper left socket site. This procedure was

[14] Exhibit D-3, page 32 of 47.

[15] The glass slide was not made a part of the exhibits packages from the parties. The glass slide's existence and the presence of the nerve tissue was confirmed during the testimony of John Evans, DDS. *See also* Exhibits D-17 and D-18.

also uneventful. The Respondent sent a pathology sample from this procedure to the Oral Pathology Group for review. The pathology report diagnosis was "left posterior maxilla, chronic fibrosing osteomyelitis".[16]

1.15 The Respondent's records he attempted to contact Patient A to encourage her to return for follow up care during the period October to December 2012. On October 30, 2012, Patient A reported she was still a bit numb on the lower left site but that it was improving.[17] This was another opportunity for the Respondent to refer Patient A to a board-certified dental surgeon to address the patient's complaints. He failed to do so. The Respondent explained that Patient A failed to return to the Respondent's officer for the follow up care, a fact the Respondent attributed to Patient A's concern regarding the outstanding dental fee amount. This fact does not relieve the Respondent from his duty to Patient A.

1.16 On December 4, 2013, Thomas Seal, DDS, began providing dental treatment to Patient A. At this visit she reported to Dr. Seal that her lower left lip was numb and had been for a year.[18] Dr. Seal then notified the Respondent by email of Patient A's complaint. According to the Respondent's records, the email indicated Patient A reported she felt numb on the lower left side of her jaw.[19] On February 12,

[16] Exhibit R-5, page 4 of 7

[17] Exhibit D-3, page 9 of 47.

[18] Exhibit D-21, page 3 of 12.

[19] Exhibit D-3, page 9 of 47.

2014, Dr. Seal recommended Patient A go to the University of Washington's Department of Oral Medicine to follow up on her lower left lip numbness complaints.[20]

1.17 On July 14, 2014, Patient A was evaluated by John Evans, DDS at the University of Washington. Patient A reported pain during the surgery on her lower left mandibular site (#17) and had been hypesthetic since that time. Patient A's complaints included biting her lip, drooling, and annoyance that she had no sensation in the area.[21] Given the length of time since the surgery, surgical repair was not possible.[22] The injury to Patient A's nerve is therefore permanent.

1.18 At the hearing the Respondent reviewed both the pre-surgical and post-surgical for Patient A. He used Patient A's post-surgical panoramic x-ray to illustrate those areas he determined supported his decision to perform cavitation surgery.[23] The Respondent believed the black voids (the dark areas reflected in the x-rays) showed a reduced bone density at the extraction sites. He opined this illustrated that Patient A's jaw was not healthy because it failed to receive the appropriate blood flow. The Respondent opinion was that these black void areas indicated an infection in those sites and supported his decision to perform the cavitation surgery to address the infection. However, both Dr. Newhouse and the Commission panel (using its experience and expertise in evaluating the x-rays) disagree. Although the x-rays reflect differences in the bone density, the differences actually reflect normal changes in bone

[20] Exhibit D-21, page 3 of 12.

[21] Exhibit D-18, page 1 of 2.

[22] Exhibit D-17, page 1 of 1.

[23] Exhibit D-16, pages 1 through 4 (pre-surgery); Exhibit D-19, page 1 of 1 (post-surgery).

density that result from the extraction of the wisdom teeth. The x-rays show no pathology, so there was no objective evidence to support the Respondent's decision to perform cavitation surgery procedures on Patient A. Performing the cavitation surgery, therefore fell below the standard of care here. As earlier stated, Patient A suffered permanent injury as a result of the Respondent's actions, as those actions caused the transection of the left inferior alveolar nerve.

1.19 Credibility Findings. The Respondent denies the allegations contained in the Statement of Charges regarding his treatment of Patient A. More specifically, he denies that he transected Patient A's left inferior alveolar nerve, given that Patient A complained of numbness during her initial visit to the Respondent.

1.20 While the Respondent's electronic treatment records note Patient A complained of numbness at the initial treatment visit, the Respondent's inability to read his own handwritten treatment notes cast some doubt on whether he made the observation contemporaneously with Patient A's first visit. Even assuming that the Respondent's handwritten records did accurately reflect that information, the Respondent failed to take appropriate steps to clarify the extent and severity of the patient's complaint. He did not properly refer Patient A out for further evaluation. There is nothing in the Respondent's records for Patient A that reflect any complaints that were later observed and recorded by Dr. Evans, namely the biting of the lip, drooling, and lack of sensation. These inconsistencies undercut the Respondent's credibility on the issue.

1.21 Dr. Newhouse contradicted the Respondent's denial that his treatment transected the left inferior alveolar nerve. Dr. Newhouse focus on the Respondent's August 2, 2012 treatment note, which support his opinion that Patient A's complaint regarding a tingling on her chin area was consistent with a patient whose left inferior alveolar nerve was recently transected. Dr. Newhouse's opinion was supported by the testimony of Dr. Evans, who observed nerve tissue on the glass slide that accompanied Patient A's pathology sample provided by the Respondent. Based on the totality of the evidence, the Commission gives more weight to the testimony of Drs. Newhouse and Evans on this issue than it does to the Respondent's testimony. The Commission finds the Respondent transected Patient A's left inferior alveolar nerve.

1.22 Sanction Exhibits. The following sanction exhibits were presented to the Commission: Declaration of Alan Anderson, dated April 10, 2019, (addressing the dental cost recovery costs associated with the investigative and hearing preparation costs); and Stipulated Settlement and Disciplinary Order, Dental Board of California, OAH No. L-200504027, dated December 19, 2006.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040.

2.2 Except as otherwise required by law, the Department bears the burden of proving the allegations set forth in the Statement of Charges by a preponderance of the evidence. WAC 246-11-520. The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing

evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), *cert. denied*, 535 U.S. 904 (2002). In 2006, the Washington Supreme Court extended the *Nguyen* holding to all professional disciplinary proceedings. *Ongom v. Dept. of Health*, 159 Wn.2d 132 (2006), *cert. denied* 550 U.S. 905 (2007). However, in 2011, the Washington Supreme Court overruled *Ongom*, but declined to overrule *Nguyen*. *Hardee v. Dept. of Social and Health Services,* 172 Wn.2d 1, 256 P.3d 339 (2011).

2.3 Given the legal uncertainty regarding the standard of proof for disciplinary proceedings, the evidence in this matter will be evaluated under both the clear and convincing standard, as well as the preponderance of the evidence standard.

2.4 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.5 The Department proved by a preponderance of the evidence and clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which states:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

The issue here is clearly not an issue of the Respondent's nontraditional dental philosophy. The standard of care violations resulted from the Respondent's failure to use his own independent dental experience and overly relying on input from Patient A and the naturopathic care recommendations. Doing so fell below the standard of care and resulted in a permanent injury to Patient A.

2.6 In its request for relief, the Department requested the most severe sanction available. In his request for relief, the Respondent seeks the dismissal of the Statement of Charges as no unprofessional conduct occurred. In the event the Commission does find unprofessional conduct here, the Respondent requests the matter be addressed by additional continuing education. In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160.

2.7 The Respondent's conduct falls in Tier B of the Practice below Standard of Care schedule. WAC 246-16-810. The panel considered the following aggravating factors when determining the sanction in this matter: prior disciplinary history in California. The panel considered the following mitigating factors when determining the sanction in this matter: none.

III. ORDER

3.1 Revocation. The Respondent's license to practice as a dentist in the state of Washington is REVOKED for a period of at least sixty months from the effective date of this Order. The Respondent may not seek licensure in the state of Washington until he has completed all of the requirements listed below, including: Dentist Professional and Evaluation Program (D-PREP) requirements listed in Paragraph 3.2; shall have paid all fines and dental cost recovery amounts as listed in Paragraphs 3.5 and 3.6; successfully completed the Western Regional Examination Board (WREB) examination in Paragraph 3.3, and shall have provided the Commission with proof of patient reimbursement in accordance with Paragraph 3.4 below.

3.2 D-PREP Skills Assessment. Within a 12-month period immediately preceding his request for licensure, the Respondent shall contact the D-PREP to schedule a dental skills assessment. Within the 12-month period, the Respondent shall undergo and successfully complete (receive an unconditional pass) a D-PREP skills assessment program that includes the following:

(A) The D-PREP skills assessment program must include, but is not limited to, areas of treatment planning and record keeping, and any other D-PREP recommended training and education.

(B) Prior to beginning the D-PREP assessment, the Respondent shall provide the D-PREP evaluator(s) with a copy of the Final Order in this matter. The Respondent shall cause D-PREP to provide a summary/outline of the assessment objective(s) to the Dental Program. The D-PREP evaluator(s) must review the Respondent's Final Order and incorporate it into the stated assessments objectives, along with the planned methodology and timelines. The summary/outline must also include terms, conditions, and dates when the Respondent needs to perform limited, supervised, and monitored work within the practice area(s) under assessment (anticipated work) for the sole purpose of evaluation and remediation.

(C) The D-PREP evaluator(s) must obtain prior approval from the Dental Program or its designee regarding the summary/outline including, but not limited to, the Respondent's anticipate work.

(D) The Respondent shall cause D-PREP to issue a final report to the Dental Program regarding the Respondent's assessment and completion of any recommended training and education. The D-PREP final report shall include, but not be limited to, assessment findings and recommendations, if any, regarding:

(1) The Respondent's ability to work with reasonable safety and skill in the evaluated practice area(s).

(2) Terms, conditions, and/or skills training the Respondent requires, if any, to work with reasonable safety and skill in evaluated practice area(s).

(E) The Respondent shall successfully complete all remedial and/or clinical education, if any, as recommended and/or specified by D-PREP. The Respondent shall abide by D-PREP recommended practice limitations and/or conditions, if any. Any restriction or condition will remain in effect until the Commission or its designee, in their sole discretion, deem the Respondent safe to practice without restrictions and/or conditions under consideration.

3.3 WREB Examination. Before the Respondent can seek licensure at the end of the revocation period, the Respondent shall successfully complete a practical examination offered by the WREB clinical examination under WAC 246-817-120(2)(a).

3.4 Patient Reimbursement. The Respondent shall return all fees he charged Patient A in this case within 12 months of the effective date of this Order and the Respondent must provide the Commission with proof of payment to Patient A upon completion of the payment.

3.5 Dental Cost Recovery. Pursuant to RCW 18.32.775, the Commission has determined the reasonable investigation and hearing preparation costs and is seeking a recovery of these expenses for one full hearing day in the amount of $6,000, and a partial recovery of investigative and hearing preparation expenses in the amount of $10,000. The Respondent must submit the dental cost recovery amount within sixty months of the effective date of this Order. The dental cost recovery fee shall be paid by certified check or money order, payable to the Department of Health, and mailed to the Department of Health, Dental Commission, at P.O. Box 1099, Olympia, Washington 98507-1099.

3.6 Fine. The Respondent shall pay a fine to the Commission in the amount of $5,000. The total amount of the fine must be received by the Commission within sixty months of the effective date of the Order. The fine shall be paid by certified check or money order, payable to the Department of Health, and mailed to the Department of Health, Dental Commission, at P.O. Box 1099, Olympia, Washington 98507-1099.

3.7 Malpractice Insurance. Once he once again obtains a license to practice dentistry in the state of Washington, and in the event he chooses not to carry malpractice insurance, the Respondent must notify all of his dental patients that he is not carrying malpractice insurance. The Respondent must create a written notice that he is choosing not to carry malpractice insurance that shall be pre-approved by the Dental Program prior to beginning his practice. Once approved, the Respondent shall have his patients sign the notice and place a copy of the signed patient notice in the patient's records.

3.8 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in her residential and/or business address within 30 days of such change.

3.9 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Final Order.

3.10 Effective Date of Order. The effective date of this Final Order is that date the Adjudicative Service Unit places the signed order into the U.S. mail. The Respondent shall not submit any fees or compliance documents until after the effective date of this Order.

Dated this 30th day of April, 2019.

Dental Quality Assurance Commission

ROBERT SHAW DMD
Panel Chair

CLERK'S SUMMARY

Charge	Action
RCW 18.130.180(4)	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Dental Program
P.O. Box 47852
Olympia, WA 98504-7852

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx