WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Regulatory Board Evaluation

Board of Dental Examiners

The Board of Dental Examiners Has An Adequate Licensing Process to Protect the Public If Followed Properly; However, the Board Needs to Engage in Proper Procedures to Ensure Public Safety

September 2005
PE 05-12-355

JOINT COMMITTEE ON GOVERNMENT OPERATIONS

Senate

Edwin J. Bowman
Chair

Billy Wayne Bailey, Jr.
Vice Chair

Walt Helmick

Donna J. Boley

Sarah M. Minear

Citizen Members

Dwight Calhoun

John Canfield

James Willison

W. Joseph McCoy

(Vacancy)

House Of Delegates

J.D. Beane
Chair

Timothy R. Ennis
Vice Chair

Joe Talbott

Craig P. Blair

Otis Leggett

Scott G. Varner, Ex Officio Non-Voting Member

OFFICE OF THE LEGISLATIVE AUDITOR

Aaron Allred
Legislative Auditor

John Sylvia
Director

Brian Armentrout
Research Manager

Gail Higgins, MPA
Acting Senior Research Analyst

Performance Evaluation and Research Division
Building 1, Room W-314
State Capitol Complex
Charleston, West Virginia 25305
(304) 347-4890

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

September11, 2005

The Honorable Edwin J. Bowman
State Senate
129 West Circle Drive
Weirton, West Virginia 26062

The Honorable J.D. Beane
House of Delegates
Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Regulatory Board Evaluation on the *Board of Dental Examiners*, which will be presented to the Joint Committee on Government Operations on Sunday, September 11, 2005. The issue covered herein is "The Board of Dental Examiners Has An Adequate Licensing Process to Protect the Public If Followed Properly; However, the Board Needs to Engage in Proper Procedures to Ensure Public Safety."

We transmitted a draft copy of the report to the Board of Dental Examiners on August 25, 2005. We held an exit conference with the Board on August 29, 2005. We received the agency response on September 6, 2005.

Let me know if you have any questions.

Sincerely,

John Sylvia

JS/wsc

Contents

List Of Appendices

Executive Summary

Issue 1: The Board of Dental Examiners Has An Adequate Licensing Process to Protect the Public If Followed Properly; However, the Board Needs to Engage in Proper Procedures to Ensure Public Safety.

The Legislative Auditor found that the Board has adequate legal authority and administrative procedures in place to license qualified practitioners.

The Legislative Auditor reviewed the licensing process of the Board of Dental Examiner to determine its adequacy in protecting the public. The Board is charged with licensing dentists in order to protect the public health and safety. The Legislative Auditor found that the Board has adequate legal authority and administrative procedures in place to license qualified practitioners. However, the requirement of immediate reporting of some types of information, the requirement of criminal background checks for licensees, and the development of a protocol for timely reporting of information to the members of the Board would strengthen the licensing process. There is also a need for the Board to define the types of situations that require immediate reporting by licensees, and to describe the actions for licensees to take.

The Board's responses to two incidences which occurred during the three-year scope of this audit, placed the public at risk because of untimely actions by the Board.

Despite an adequate process to license dental practitioners, the Legislative Auditor found that the Board's responses to two incidences which occurred during the three-year scope of this audit, placed the public at risk because of untimely actions by the Board. In the first incidence, which was a mortality report relating to the administration of general anesthesia, the Board staff did not provide timely information to the Board members. Following the members' receipt of information at the time of the licensee's renewal application for his anesthesia permit, the Board did not investigate the cause of the incidence in order to evaluate the risk to the public safety. The Board did not investigate this incidence until it received a complaint 14 months after the mortality occurred.

The second incidence involved a dentist who was practicing on patients while in a confused and disoriented condition. The Board received a complaint, and its investigation verified the situation, so the Board immediately suspended the dental license, and set a hearing date for 80 days in the future. This meant that the Board was prepared to keep the dentist from practicing for 80 days. However, the Board did not afford proper due process to the dentist, and so reinstated the license after about two weeks. When the license was reinstated, the cause of the dentist's behavior was unexplained, the public was still at risk and the Board's initial concerns for the public safety had not been alleviated. The Legislative Auditor contends that the situation warranted action to restrict the dentist's practice as soon as possible in order to protect the public. The

Board had the legal authority to apply to circuit court for an injunction to keep the dentist from practicing, but did not take this action. Further, the Board kept the same hearing date in the future instead of trying to expedite the hearing process in order to limit the public risk while protecting the licensee's due process rights.

The Board's responses to these two incidences appear to be due to poor judgement on the part of the Board. There is an apparent need for the staff and Board members to receive appropriate training with respect to the proper response to situations that present a threat to the public.

The Board's responses to these two incidences appear to be due to poor judgement on the part of the Board.

Recommendations

1. *The Board of Dental Examiners should respond appropriately to all serious reports of malpractice and serious incidents as its authority allows.*

2. *The Board of Dental Examiners should adopt a definition of serious incidents and a policy and procedure on how to receive information and how to disseminate such information to Board members.*

3. *The Board of Dental Examiners should require a criminal background check at the time of the application for a dental license, and periodically thereafter.*

4. *The Board of Dental Examiners should require that licensees report all malpractice lawsuits at the time of filing.*

5. *The Legislature should consider requiring all professional practitioners licensed by Chapter 30 boards to report all malpractice lawsuits at the time of filing to their respective licensing boards.*

Review Objective, Scope and Methodology

The West Virginia Sunset Law, Chapter 4, Article 10 requires the Legislative Auditor to conduct a Regulatory Board Evaluation of the Board of Dental Examiners prior to July 1, 2006. The evaluation is required to assess whether the Board complies with the policies and provisions of Chapter 30 of the West Virginia Code, all other applicable laws and rules; whether the Board follows a disciplinary procedure which observes due process rights and protects the public interest; and whether the public interest requires that the Board be continued.

Objective

Prior to this evaluation, the Legislative Auditor was aware of a death that had occurred in 2002 following oral surgery. The knowledge of this event led the Legislative Auditor to review the licensing procedures of the Board of Dental Examiners to determine whether the Board is protecting the public health and safety through its licensing procedures. For this evaluation the Legislative Auditor reviewed the process of licensing new dental practitioners, and renewing dental licenses and anesthesia permits. The intent of the evaluation was to examine if the Board had adequate legal authority to respond appropriately to any incident that may place the public at risk. Also, the review intended to examine the Board's process of requesting and receiving appropriate information, and the decisions that resulted from this process.

Scope

This evaluation covers the period from January 2002 through August, 2005.

Methodology

This evaluation was developed from a review of the West Virginia Code, interviews with the staff members of the Board of Dental Examiners, examinations of Board meeting minutes and complaint files. Information gained from the Board staff was specific in regard to actions taken by the Board in the two situations examined for this evaluation. Individual members of the Board were not interviewed because the factual evidence and the assistance from the Board's staff were sufficient to provide complete information regarding the response of the Board in the two situations. Every aspect of this evaluation complied with **Generally Accepted Government Auditing Standards (GAGAS).**

Issue 1

The Board of Dental Examiners Has An Adequate Licensing Process to Protect the Public If Followed Properly; However, the Board Needs to Engage in Proper Procedures to Ensure Public Safety.

Issue Summary

The Board of Dental Examiners is charged with licensing dentists in order to protect the public health and safety. The licensing process includes licensing applicants for new licenses and renewing licenses for practicing practitioners. The Board has adequate legal authority and administrative procedures in place to license qualified practitioners or to deny, suspend or revoke licenses to protect and safeguard the general public. The Board also requests and receives adequate information between renewal periods to adequately oversee the performance of current licensees, but there is room for strengthening this area. Although the Board has an adequate licensing process, the Board needs to follow proper procedures to safeguard the public. In one case when the death of a patient was reported to the Board's staff by an oral surgeon in December 2002, the Board's staff did not respond to the initial call from the dentist by immediately informing Board members. When Board members were informed in July 2003 during the renewal application of the dentist's anesthesia permit, the Board did not initiate an investigation to review and evaluate the dentist's anesthesia procedures. The Board continued to renew the dentist's specialty license and anesthesia permit for three years after the incident. Action was taken by the Board only after a complaint was made to the Board in February 2004.

Although the Board has an adequate licensing process, the Board needs to follow proper procedures to safeguard the public.

Another incident occurred when a patient complained that a dentist was practicing in a confused and disoriented manner. An initial investigation found that this situation had occurred on other occasions. The Board immediately suspended the license but without giving the licensee proper due process. At the same time that the Board suspended the license, it also scheduled a hearing for June 4, 2004. About two weeks later the Board reinstated the license because it acknowledged the license was suspended improperly. When the Board reinstated the license it also amended the complaint and kept the hearing scheduled for June 4. However, when the license was reinstated, the cause of the dentist's behavior was still unexplained, the public was still at risk, and the Board's initial concerns for public safety had not been alleviated. The Legislative Auditor contends that the circumstances warranted action to restrict the dentist's practice as soon as possible, in order to protect the public. The Board had the

legal authority to apply in circuit court for an injunction to enjoin the dentist and stop him from practicing. If this action had failed, the Board could have limited the amount of time that the dentist was practicing through setting a hearing date sooner than June 4 and still give the licensee due process. Instead, after reinstating the license, the Board pursued a course of action that allowed the dentist to continue to practice without restriction for a period of time that placed the public at risk. Instead of suspending the license as soon as possible using proper procedures, the Board followed a course of action that took seven months and resulted in the Board entering into a settlement agreement that states that it should not be construed "*as a disciplinary action taken by the Board.*" The settlement agreement was entered into against the legal advice of the Board's counsel. Also, no formal action was taken against the dental hygienist who was aware of the unsafe environment and did not report it to the Board as she is required by law.

There is an apparent need for the staff and board members to receive appropriate training with respect to the proper response to incidents that present a threat to the public.

The responses to these two incidences appear to be the result of poor judgement on the part of the Board. There is an apparent need for the staff and board members to receive appropriate training with respect to the proper response to incidents that present a threat to the public. There also is a need for the Board to establish appropriate protocol for defining the types of situations that require immediate reporting by licensees, and to describe the types of action to take.

The Board of Dental Examiners Has An Adequate Process for Issuing New Licenses

The regulation of professions in the state has at its foundation the protection of the public and oversight of the practitioner. In Chapter 30-1-1a, the Legislature explains that:

> *"... The fundamental purpose of licensure and registration is to protect the public, and any license, registration, certificate or other authorization to practice issued pursuant to this chapter is a revocable privilege."*

The Board of Dental Examiners has statutory authority under §30-4-5 to issue, renew, deny, suspend, revoke or reinstate licenses, and discipline licensees.

The Board of Dental Examiners has statutory authority under §30-4-5 to issue, renew, deny, suspend, revoke or reinstate licenses, and discipline licensees. The Board has an adequate administrative process to license new dentists that adheres to general guidelines issued by the American Dental Association. The

process is as follows:

- **New dentists.** West Virginia applicants must pass a clinical board such as the North East Regional Board (NERB) based on knowledge and clinical skills, and a national written exam from the American Dental Association. Other applicants must pass a state or regional clinical board exam comparable to NERB and the ADA written exam. The clinical skills part of the board exam is conducted at the state dental schools by a team consisting of in-state and out-of-state dentists. NERB issues the final results to the Board. In addition, the applicant must document education and complete a medical exam, pass an examination on specific laws, submit two recommendations and be interviewed by the Board.

- **Speciality licenses.** Following the award of a general license, the dentist can apply for a speciality license that limits the dentist to practice only in the speciality but allows advertising of the licensed speciality. In order to receive the specialty, the dentist is examined by a team of dentists practicing the speciality in the state. The team reviews the dentist's credentials and interviews the dentist. After receiving the speciality, only one license is issued to the dentist annually. Specialities are issued in eight areas in the practice of dentistry in the state: oral surgery; orthodontics; oral pathology; periodontics; prosthodontics; pediatric dentistry; endodontics and public health.

- **Dentists licensed by other states.** Dentists may come into the state and receive a license if their license in another state is not under discipline, they meet the general standards for licensure in West Virginia, and they have no felony convictions. Information about out-of-state licensed dentists is transmitted through the National Practitioner Data Bank.[1]

There are 53 anesthesia permits issued presently by the Board to oral surgeons in the state.

- **Anesthesia permits.** There are 53 anesthesia permits issued presently by the Board to oral surgeons in the state. These are required by state code when anesthesia is delivered intravenously by the oral surgeon in the dental office. Two members of the Board's Anesthesia Committee (who are also permit holders) examine anesthesia permit holders, and inspect their facilities. Re-examinations, and facility inspections are conducted every five years. New facilities are inspected before they are allowed to be used.

[1]*The National Practitioner Data Bank is a national alert system for information to direct inquiry into specific areas of a practitioner's licensure, medical malpractice payment history, and record of clinical privileges. State licensing boards have access to this information.*

The Process of Oversight Between Renewal Periods is Adequate but Could be Improved

An important stage of licensure is the process of determining whether to renew, suspend, or revoke a license of a current licensee based on the ongoing oversight of a licensee's qualifications and competency.

Licenses and anesthesia permits are renewed on an annual basis, but not on the same cycle. An important stage of licensure is the process of determining whether to renew, suspend, or revoke a license of a current licensee based on the ongoing oversight of a licensee's qualifications and competency. Once a practitioner is licensed, the Board must have adequate and timely information to ensure that a licensee is continuing to practice dentistry to the standards required by the Board to protect the public health and safety. This information is needed at the time of renewal as well as between renewal periods.

The Legislative Auditor finds that the Board requests or receives information at or between renewal periods regarding the performance of licensed dentists. Such information can come through a complaint initiated by a citizen, or a Board member or through some other means. If the Board receives information regarding incompetence or inappropriate practices of a dentist, the Board has authority to investigate and determine probable cause before taking any disciplinary action against a licensee. The Board also has the power to seek an injunction against the practice of a professional if immediate action is necessary. Also, as of 2005, all licensing boards have the statutory authority to immediately suspend a license if a board determines that the public is in immediate danger.

In reviewing the licensing process, the Legislative Auditor identified four areas that can be strengthened. They are:

Defining what constitutes a reportable event, and requiring that such information be submitted at the time the incident occurs will improve the Board's ability to protect the public.

- **The Board does not require licensees to report a serious incident at the time it occurs.** Although the Board began requiring that dentists renewing their licenses in 2005 report complaints, disciplinary actions or consent orders filed by any person, hospital, dental society or dental board, and any malpractice judgements against the dentist or insurance settlements, this information is required to be reported only at the time of renewal. Dentists with anesthesia permits are required to report any mortality or morbidity associated with the use of sedation and/or general anesthesia. The license and anesthesia permit renewal cycles are such that this information could be received by the Board as long as 12 months after the event. In addition, this requirement limits not only when the events are to be reported to the Board, but also defines which events are to be reported. Other serious incidents might occur during the dentist's practice which should also be reported immediately to the Board. Defining what constitutes a reportable event, and requiring that

such information be submitted at the time the incident occurs will improve the Board's ability to protect the public.

- **The Board does not require a licensee to report malpractice lawsuits at the time of filing against the practitioner.** The Board required for the first time in 2005 that practitioners renewing their licenses report malpractice settlements in the past year. The way the request is worded, the licensee would not have to report the malpractice case until after it has been settled, which could be years after the incident occurred. The allegations or incidents in a malpractice suit could be grounds for the Board to investigate to determine if appropriate action is necessary. Therefore, it is necessary that the Board receive such information at the time of the filing of the malpractice suit to evaluate the seriousness of the incident and whether the public is at risk. **This information should be forwarded to the Board not only at the time of renewal, but also at any time between renewal periods.**

The allegations or incidents in a malpractice suit could be grounds for the Board to investigate to determine if appropriate action is necessary.

- **The Board does not require that information about serious incidents and malpractice lawsuits be immediately forwarded to the board members.** When a death occurred in an oral surgeon's office in 2002, the surgeon informed the Board by telephone on the date of the incident. However, members of the Board did not learn of the patient death until seven months later when the oral surgeon applied to renew his anesthesia permit in 2003. An incident of this nature should have been immediately forwarded to each Board member in order to expedite any decisions and take any immediate actions necessary to protect the public.

An incident such as the death of a patient should have been immediately forwarded to each Board member in order to expedite any decisions and take any immediate actions necessary to protect the public.

- **The Board does not require criminal background checks.** The Board is required to issue licenses to new applicants who are of good moral character. The Board can suspend or revoke a license from any dentist convicted of a felony. However, the Board presently relies on information from the applicant, or the in-state licensee to determine legal status and lack of a felony conviction. By not requiring criminal background checks for dentists practicing within the state, the Board fails to gather all information available to it to assure that the public is protected.

Passage of Senate Bill 737 during the 2005 regular legislative session strengthened all regulatory boards by authorizing all boards to suspend or revoke a certificate, license, registration or authority prior to a hearing if the person's continuation in practice constitutes an immediate danger to the public. Before

the passage of Senate Bill 737, the Board would have had to start a legal proceeding for an injunction to enjoin the dentist's activities. The authority granted in 2005 allows the Board to act more quickly in the event that a licensee presents an immediate danger to the public.

The Board's Response in Two Cases Placed the Public at Risk

Despite an adequate process to license dental practitioners and protect the public, the Board's responses to two incidences that occurred during the three-year scope of this audit placed the public at risk because of untimely actions.

Despite an adequate process to license dental practitioners and protect the public, the Board's responses to two incidences that occurred during the three-year scope of this audit placed the public at risk because of untimely actions. In the first case, the Board put the public at risk when it did not investigate a mortality report received from an oral surgeon on the day of the death of a patient, nor did the Board respond to this same information when it was reported during the permit renewal process seven months later. The following is the sequence of events of this incident:

The Board's staff did not take appropriate action upon receiving this incident report, in that the Board members were not immediately informed by the staff.

In December of 2002, an oral surgeon experienced the death of a 13-year-old patient, apparently as the result of general anesthesia administered in the dental office. On the day of this event, the oral surgeon contacted the Board and verbally reported what had happened. The office manager who spoke to the oral surgeon immediately informed the executive secretary of the Board. The Board's staff did not take appropriate action upon receiving this incident report, in that the Board members were not immediately informed by the staff. Based on the Board's meeting minutes for meetings that occurred in January, March, April and May of 2003, this incident was not reported by the staff to the members of the Board. The evidence indicates that Board members were first informed of the patient death during a July, 2003 meeting in which the oral surgeon's anesthesia permit renewal report was distributed. The incident and the dentist's anesthesia permit renewal was discussed in executive session. **After learning about the patient death, Board members took no action to ensure the public safety.** This unusual and serious event did not cause the Board to investigate to determine if the oral surgeon was practicing in a safe manner and should continue to have an anesthesia permit. Instead, the Board continued to license the oral surgeon and renewed his anesthesia permit.

The Board took no action to assess the risk to the public until a complaint was lodged with the Board by the patient's family in February, 2004.

The Board renewed the oral surgeon's anesthesia permit in July, 2003, and subsequently in 2004 and 2005. In addition, the oral surgeon's specialty license was renewed for 2004 and 2005. The Board took no action to assess the risk to the public until a complaint was lodged with the Board by the patient's family in February, 2004. Following the complaint, the Board investigated the actions of the oral surgeon, and involved an expert to review the dental records.

As of August, 2005 the Board, while working toward a consent decree, had not resolved the disciplinary action and the oral surgeon continued in practice.

In late January, 2004 the Board received a complaint from a patient of a dentist who seemed confused or disoriented during a dental examination of the patient in December of 2003.

A second incident occurred in which the Board placed the public at risk. In late January, 2004 the Board received a complaint from a patient of a dentist who seemed confused or disoriented during a dental examination of the patient in December of 2003. **The Board did not send a copy of the complaint to the licensee to allow him to respond to the allegations against him.** Instead, five days later the Board sent its investigator to the licensee's office and proceeded to question the licensee and his employees. An employee who was present on the day of the incident was asked by the investigator, "*What condition was [doctor's name] in that day?*" The employee replied: "*Almost unexplainable. He was very, very out of it. Very spacey. He couldn't make a complete sentence. He repeated everything probably five or six times.*" The investigator continued, "*How long has this been going on?*" The employee replied: "*Well, February the 12th I'll be here two years. Off and on ever since I have been here.*" The investigator asked again: "*For two years?*" The employee reiterated: "*For two years.*" The investigator then asked the employee if in the past two years had the dentist ever worked on a patient in that condition? The employee stated: "*Unfortunately, yes.*"

The investigator's initial report indicated that the dentist was experiencing problems that could have caused harm to his patients and this condition had been going on for at least two years prior to the reported incident.

The investigator learned that employees of the dental office drove the dentist home on the day of the incident. The dentist could not remember his home address, and the employees had to look it up before taking him home. The investigator questioned another employee and asked: "*During the time that you have worked here, has [doctor's name] been acting a little funny? Like he has been on something, or acting kind of weird?*" The employee answered: "*There have been times, that his behavior has been questionable.*" The investigator also asked this employee if on days that she was present had she ever seen him come in to where she didn't think that he should be working on any patients? The employee answered: "*One time.*" The investigator's initial report indicated that the dentist was experiencing problems that could have caused harm to his patients and this condition had been going on for at least two years prior to the reported incident.

When the Board met for a regularly scheduled meeting in March, 2004, it suspended the dentist's license based on the investigator's report, but without giving the licensee notice that disciplinary action against his license would be discussed at the Board meeting.

When the Board met for a regularly scheduled meeting in March, 2004, it suspended the dentist's license based on the investigator's report, but without giving the licensee notice that disciplinary action against his license would be discussed at the Board meeting. In 2004, the Board did not have the legal authority to immediately suspend a license without a hearing, and it did not follow proper procedures to notify the licensee. Instead, the Board ordered that the dental license be suspended, set a date for a hearing, and then formally informed the licensee of the details of the complaint. The hearing was set for

June 4, 2004 which was 80 days *after* the suspension of the license, which indicates that the Board was prepared to prevent the dentist from practicing for 80 days. Although the actions of the Board were in direct violation of its own legislative rules in that it did not give required notification to the licensee prior to a license suspension, it is obvious the Board had such serious concerns about public safety that it felt such action was necessary.

The result was that the Board reinstated the license 16 days after it was suspended.

Upon being informed of the suspension of his dental license, the dentist retained an attorney who requested the license be reinstated and provided the Board a copy of a Petition for Review that would be filed in circuit court that indicated that the Board violated the dentist's due process rights by suspending the dental license without a hearing. The proposed Petition for Review stated the following violations of the Board:

Although the actions of the Board were in direct violation of its own legislative rules in that it did not give required notification to the licensee prior to a license suspension, it is obvious the Board had such serious concerns about public safety that it felt such action was necessary.

- failure to give him a copy of the complaint;
- failure to afford the dentist an opportunity to file a written response;
- failure to provide the dentist with notice that the Board was going to take action in the case;
- failure to present the dentist with a statement of charges before suspension; and
- failure to afford the dentist an opportunity to be heard on all issues.

The result was that the Board reinstated the license 16 days after it was suspended. It should be noted that at the time the Board reinstated the license, it did so only because it acknowledged the license was suspended improperly. At the time the license was reinstated, the cause of the dentist's behavior was still unexplained, the public was still at risk, and **the Board's initial concerns for public safety had not been alleviated.** The circumstances warranted proper and immediate action to restrict the dentist's practice until the matter could be resolved. Since the Board did not have the legal authority to immediately suspend the dentist's license, it could have pursued a civil remedy by petitioning a circuit court to enjoin the dentist from practicing. Instead of going to court to try to stop the dentist from practicing, the Board pursued a course of action that allowed the dentist to continue to see patients, even though the circumstances had not changed. **The Board continued with the hearing date previously set for 80 days, which now allowed the dentist to practice without any restriction for the same period during which the Board had originally wanted to the stop the dentist from practicing.** The Board set the hearing to consider disciplinary action against the dentist, and then postponed hearing the case because the Board was negotiating a settlement agreement. The settlement agreement specifically states that the Board was not taking disciplinary action against the dentist. Entering into the settlement agreement was done

Instead of going to court to try to stop the dentist from practicing, the Board pursued a course of action that allowed the dentist to continue to see patients, even though the circumstances had not changed.

against the legal advice of its counsel. Also, no formal action was taken against the dental hygienist who was aware of the unsafe environment and did not report it to the Board as required by law.

The Board continued to interview other staff in preparation for the hearing and the dentist was able to continue his practice. In these other interviews the investigator found that the dentist's behavior was common place as far as the employees were concerned.

During the period prior to the June 4 hearing date, the Board continued to interview other staff in preparation for the hearing and the dentist was able to continue his practice. In these other interviews the investigator found that the dentist's behavior was common place as far as the employees were concerned. In fact the investigator quoted the dental hygienist as saying that on the day of the incident, *"...I just had my usual conversation with the assistant, and said, 'You know is this one of those days?' and she said, 'Yes it is.'"*

After the initial investigation but prior to the suspension of the dentist's license, the Board also learned that the dentist was unable to work after coming into his office one day, and office staff again had to transport him home. Furthermore, another episode occurred following the reinstatement of the license. The dentist's license was reinstated on April 2, 2004 and on April 20, 2004 the dentist had problems that prevented him from safely practicing on patients in his office. In this event, the dentist became incapacitated while at work. The dental staff made three telephone calls to the Board that day. During the first call the dentist's staff stated to the Board that: *"...we need help, we can not work under these conditions, this is ... awful."* The Board contacted the dentist's attorney who went to the dental office and assisted the dentist and the staff.

The dentist's license was reinstated on April 2, 2004 and on April 20, 2004 the dentist had problems that prevented him from safely practicing on patients in his office.

One of two dental hygienists in the office was later interviewed by the Board's investigator: *"He [the dentist]checked my second patient an hour and a half into the morning, and didn't have much control over his motor skills. He trips over and falls quite a bit coming in to see a patient... ."* Another staff member stated that she understood that the dentist got his feet tangled in hoses and pulled them out of the wall. She stated that the hygienist told her that *"water and air was spraying everywhere, and she put them back up on there and sat down, and he just...took forever to do an exam, just staring ...at stuff. Then he just sat there with his head down after the patient left."* The dentist subsequently tripped down stairs at the back of the building, fell and the staff found him lying in the grass outside the building. The dentist voluntarily closed his office for a period of time while he received medical treatment.

Despite these occurrences during the intervening time of resolving this case, the Board did not take any legal course of action to enjoin the dentist's practice.

Despite these occurrences during the intervening time of resolving this case, the Board did not take any legal course of action to enjoin the dentist's practice. Although the dentist's office was voluntarily closed for a period of time, he was still legally able to practice.

The Board drafted a consent decree that would require several actions by the dentist, including a requirement for the dentist to undergo an independent examination (to determine whether his medical condition in any way restricted his ability to practice dentistry), and to keep an emergency protocol in effect and posted at the dental office for the duration of the dentist's medical treatment. However, the consent decree was changed to a "Settlement Agreement" at the request of the dentist, and the requirement for an independent evaluation of the dentist's medical condition was removed. Instead the settlement agreement required the dentist to continue to receive treatment for his condition. Furthermore, the agreement **released the dentist from any disciplinary action by the Board and required that the Board would not report the incident as disciplinary action to the National Practitioner Data Bank.** The Board's Assistant Attorney General (AG) advised against taking this action. However, the Board ignored the advice of the Attorney General's office and signed the settlement agreement with the dentist.

The Board entered into a settlement agreement that stated that no disciplinary action against the dentist would be taken by the Board.

The Board responded to the Legislative Auditor concerning why it entered into the settlement agreement against the legal advice of its Assistant Attorney General. In a letter dated August 22, 2005, the Board stated that:

> *"[The AG] forwarded the re-drafted Settlement Agreement to opposing counsel [for the dentist] with changes he had requested and indicated the Board had agreed to the same during telephone communications.... However, the Board had no meeting...and had never reviewed and considered acceptance of the Settlement Agreement... . Therefore, the Board was put in a position to accept the Settlement Agreement as a result of the correspondence of [the AG]... . It should be noted that evidence obtained, after filing of the matter, disclosed that the resolution was an acceptable conclusion to the pending matter. The evidence in the case disclosed that [named dentist] was not aware of what was occurring and at all times was seeking proper medical attention."*

The Board entered into the settlement agreement against the advice of its Assistant Attorney General.

Despite the Board's comments regarding why it entered into the settlement agreement, the Legislative Auditor has concerns regarding the actions of the Board in regard to protecting the public in this case:

- When informed initially of the situation, the Board had major concerns. Following its own investigation, the Board concluded that the situation in the dental practice was serious enough to warrant **immediate suspension** of the dentist's license.

- The Board restored the dentist's license only because it acknowledged the improper suspension. The dentist's behavior was still unexplained, and the circumstances still warranted immediate action to restrict the dentist's practice. Instead of taking court action to stop the dentist from practicing, the Board continued to gather information for an anticipated hearing set 80 days in the future from the license suspension. By not taking all avenues available to the Board to stop the dentist from public contact, the Board placed the public at risk, which was demonstrated by the events of April 20, 2004. If the court had not agreed that the dentist should be enjoined from practice, the Board should have set a hearing date at the soonest time possible in order to limit the dentist's exposure to the public. The Board allowed the dentist to practice *while knowing that the dentist had an unexplained problem that was seriously affecting his ability to practice dentistry safely*.

In the first case the Board failed to act in a timely fashion, while in the second, the Board's failure to follow proper procedures caused it to rescind (reinstating a dental license that it had suspended) an action it had taken in order to protect the public.

- The Board also did not take any formal action against the dental hygienist who was aware for at least two years that the dentist was having periodic episodes that could harm patients and did not report it to the Board as is required by West Virginia Code §30-1-5(b).

There also is a need for the Board to establish appropriate protocol for defining the types of situations that require immediate reporting by licensees, and to describe the types of action to take.

The preceding two cases involving licensees represent untimely responses by the Board that placed the public at risk. These cases raise a major concern about the Board's performance. In the first case the Board failed to act in a timely fashion, while in the second, the Board's failure to follow proper procedures caused it to rescind (reinstating a dental license that it had suspended) an action it had taken in order to protect the public. Following the reinstatement of the license, the Board did not continue to attempt to protect the public by enjoining the dentist from practicing. If the Board was unable to stop the dentist from practicing through the circuit court, it could have then set a hearing date that was sooner than the 80 days set at the time of the license suspension and retained when the license was reinstated.

Conclusion

The Board has adequate legal authority and administrative procedures in place to protect the public through the process of licensure. However, the Legislative Auditor identified two separate incidences in which the Board's untimely responses placed the general public at risk of harm. These responses appear to be the result of poor judgement. There is an apparent need for the staff and board members to receive appropriate training with respect to the proper response to incidents that present a threat to the public. There also is a

need for the Board to establish appropriate protocol for defining the types of situations that require immediate reporting by licensees, and to describe the types of action to take.

Despite the adequacy of the licensing process, the Legislative Auditor identified a few areas where it could be strengthened. Some weaknesses in the information-gathering process provide gaps to the protection of the public. In particular, the Board does not require licensees to report malpractice lawsuits and the circumstances surrounding the lawsuit at the time of filing. The allegations or incidents in a malpractice suit could be grounds for the Board to investigate to determine if appropriate action is necessary. Currently, the Board allows malpractice lawsuits to be reported upon settlement, which could be several years after the occurrence. The Board has always required incidents relating to anesthesia to be reported when the annual anesthesia permit is renewed. However, the Board should consider requiring serious incidents to be reported at the time of occurrence. Furthermore, such incidents should also be required to be forwarded to Board members immediately. Finally, the Board should consider requiring criminal background checks for new licensees and periodically during renewals as often as the Board determines.

Recommendations

1. *The Board of Dental Examiners should respond appropriately to all serious reports of malpractice and serious incidents as its authority allows.*

2. *The Board of Dental Examiners should adopt a definition of serious incidents and a policy and procedure on how to receive information and how to disseminate such information to Board members.*

3. *The Board of Dental Examiners should require a criminal background check at the time of the application for a dental license, and periodically thereafter.*

4. *The Board of Dental Examiners should require that licensees report all malpractice lawsuits at the time of filing.*

5. *The Legislature should consider requiring all professional practitioners licensed by Chapter 30 boards to report all malpractice lawsuits at the time of filing to their respective licensing boards.*

Appendix A: Transmittal Letter

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

August 25, 2005

John F. Parkulo, Executive Secretary
Board of Dental Examiners
207 South Heber Street
Beckley, WV 25802

Dear Mr. Parkulo:

This is to transmit a draft copy of the first issue of the Regulatory Board Review of the Board of Dental Examiners. This report is scheduled to be presented during the September 11, 2005 interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committee may have.

We need to schedule an exit conference to discuss any concerns you may have with the report. We would like to have the meeting on Monday, August 29, 2005 either in person at our office in Charleston, or via teleconference. Please notify us to schedule an exact time. In addition, we need your written response by noon on Friday, September 2, 2005 in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, September 8, 2005 to make arrangements.

We request that your personnel not disclose the report to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Appendix B: Agency Response

WEST VIRGINIA BOARD OF DENTAL EXAMINERS
207 S. HEBER STREET
BECKLEY, WV 25801
(304) 252-8266
Toll Free (877) 914-8266
FAX (304) 253-9454
www.wvdentalboard.org
wvbde@charterinternet.com

September 6, 2005

RECEIVED
SEP 06 2005
PERFORMANCE EVALUATION AND RESEARCH DIVISION

Ms. Gail V. Higgins, MPA
Office of the Legislative Auditor
Performance Evaluation & Research Division
Building 1, Room W-314
1900 Kanawha Blvd., East
Charleston, WV 25305-0610

RE: Regulatory Board Review of the Board of Dental Examiners

Dear Ms. Higgins:

The West Virginia Board of Dental Examiners, hereby submits the following information in response to the preliminary report of the Performance Evaluation and Research Division dated August 30, 2005.

The West Virginia Board of Dental Examiners has diligently strived to make changes to existing laws to better address the fundamental purpose of this Board, as set forth by this Honorable Legislature.

Furthermore, the West Virginia Board of Dental Examiners has, since the year 2001, requested various changes to the laws of the State of West Virginia as they relate to the practice of Dentistry in an effort to protect the public.

In that respect, the West Virginia Board of Dental Examiners requested legislative changes to the entire Dental Practice Act, the same of which was re-written in 2001 as a result of said request. The initial thrust of the change to the West Virginia Dental Practice Act was to better address the ability of the West Virginia Board of Dental Examiners to suspend or revoke licensure and engage disciplinary actions as currently set forth in Chapter 30, Article 4, Section 20 of the West Virginia Code. Previously, laws as they related to the practice of Dentistry in the State of West Virginia, had language indicating

that disciplinary action could be taken for gross ignorance and gross inefficiency in the profession. This language was considered by legal reviews to be overly broad and vague, and, therefore, subjected the West Virginia Board of Dental Examiners to having any decisions overturned from an appellate standpoint. As it related to the request of the West Virginia Board of Dental Examiners to better address their abilities to suspend or revoke a license for purposes of protecting the public, not only were the changes made as requested by the Board, but also numerous changes were made to the West Virginia Dental Practice Act as found in Chapter 30, Article 4 of the West Virginia Code to better address the legal functioning and application of the West Virginia Board of Dental Examiners for the protection of the public as delegated to this Board by the West Virginia Legislature. However, summary suspension power was not given to the Board during the Legislative re-write.

After the changes to the West Virginia Dental Practice Act in 2001, a need was found to expand the duties of the auxiliaries within the dental practice, specifically dental hygienists and dental assistants, which was accomplished by legislation promoted by the West Virginia Board of Dental Examiners in the 2003 legislative session. Furthermore, the West Virginia Board of Dental Examiners, over the span of five years, had been working on a comprehensive anesthesia bill to specifically address the administration of general anesthesia in dental offices as previously found in Chapter 30, Article 4A of the West Virginia Code. This law was completely re-written with a new comprehensive piece of legislation as promoted by the West Virginia Board of Dental Examiners and approved by this Honorable Legislature in 2005. The Board also engaged various rules and regulations to promote procedural effectiveness and comply with open governmental meetings. The Board further requested summary suspension legislation for the West Virginia Board of Dental Examiners, which was refused by the Legislature in the 2005 session. However, during the 2005 legislative cycle, the Legislature of the State of West Virginia saw fit to give all Chapter 30 Boards summary suspension power as currently found in Chapter 30, Article 1, Section 8 of the West Virginia Code.

The West Virginia Board of Dental Examiners recognizes that all the changes they have requested, in their respectful opinion, were, in fact, necessary to ensure the public's safety in the proper discharge of their duties. The Board of Dental Examiners recognizes that while tremendous strides have been made to further advance and conform to this prime directive, there is certainly room for improvement, and the Board will continue to discharge their responsibilities as clearly reflected by the herein above set- forth comments.

As it relates to the report as set forth by the Performance Evaluation and Research Division, it should be noted that two specific matters are presented to this legislature to draw the conclusion as set forth in the document as prepared by the Auditor's Office. Approximately 150 complaints were processed by the West Virginia Board of Dental Examiners and/or are currently engaged in the complaint process, between the period of January 2002 to July 2005. All requested information has been transferred to the Performance Evaluation and Research Division in order to properly review the Board

pursuant to Sunset Legislation as enacted by this Legislature.

The West Virginia Board of Dental Examiners respectfully takes opposition to the conclusions drawn by the Performance Evaluation and Research Division based upon the two complaints that were reviewed and set forth in their report leading to the opinion and conclusion as set forth under issue one. First of all, the West Virginia Board of Dental Examiners denies that it had an adequate licensing process to protect the public, if the licensing process includes complaint procedures. As it relates to disciplinary procedures and the process for discipline in the practice of Dentistry in the State of West Virginia, the West Virginia Board of Dental Examiners is of the opinion that the two cases in question clearly demonstrate inadequacies in the law that have been acknowledged and are being addressed by the Board. The report also verifies this by asserting that injunctive relief was available to this Board. Injunctive relief is an extraordinary remedy at law. In order to seek injunctive relief the Board would have to set forth they had no other adequate remedy at law.

Given that the two complaints in question contain privileged information, the Board will only address the actions of the Board as it relates to the two matters in a generic fashion, without naming parties and/or engaging in statements which could jeopardize the West Virginia Board of Dental Examiners' responsibility in protecting privileged information.

It is alleged that in two instances the West Virginia Board of Dental Examiners did not use proper procedure to ensure public safety. The West Virginia Board of Dental Examiners asserts that such statement is inaccurate concerning the two cases involved.

In the matter concerning the death of a patient in a dental office, it is alleged the Board failed to properly prosecute the matter based upon a phone communication from the practitioner on the date of occurrence. At the time the matter was reported, by phone communication from the practitioner, the West Virginia Board of Dental Examiners had no legal authority in place to effectively instruct on how to handle the communication of the practitioner.

The West Virginia Board of Dental Examiners did recently make a change to their anesthesia licensing procedures which added circumstances concerning anesthesia incidents on renewal applications. The anesthesia permit renewal changes advanced by the Board were made effective for the year 2001. Then the Performance Evaluation and Research Division finds the Board did not act when the matter was again reported on the renewal form by the practitioner for the year 2003, which again documented the death incident which occurred in the year 2002.

The West Virginia Board of Dental Examiners admits the Board did not have a procedure in place at the time, and, therefore, action was not taken simply upon information that the death occurred. While, the Board does acknowledge that it had the ability to investigate any alleged violation under applicable law at the time, the reporting is not alleging a violation. It is the Board's position that clear legal directive needs to be

implanted to require such circumstances and direct the Board to do such an investigation in serious incident matters. However, it is the Board's position that they certainly did not violate the protection of the public safety entrusted in them as it relates to this specific case due to the failure of any specific laws to authorize such actions by the Board. The Board further submits that it did, in fact, continue to renew the dentist's license for three years after the incident. The actual complaint to the West Virginia Board of Dental Examiners concerning the incident in question was not filed with the Board Office until February 2004 in conformance with the complaint procedures in effect with the West Virginia Board of Dental Examiners. This case has not been finalized as of this date.

The Board would like to specifically note as it relates to this incident that the West Virginia Board of Dental Examiners, to the knowledge of the Executive Secretary, has never been involved in a death case as it relates to the practice of Dentistry. While the West Virginia Board of Dental Examiners laws are being re-evaluated to better address this matter with the hindsight of this occurrence, the same were not in place at the onset. Therefore, to state the Board did not protect the public in this matter is an inaccurate representation as it relates to the West Virginia Board of Dental Examiners.

The matter is still pending before the West Virginia Board of Dental Examiners as it relates to this fatality. Therefore, the Board is not at liberty to further discuss the circumstances, but will assure members of this Legislature that the West Virginia Board of Dental Examiners has been following its directives as it relates to the proper discharge of this matter. This particular case involves numerous matters which the Board will defer to legal counsel for further addressing based upon the fact that it is still a pending matter before the Board, and an abundance of caution must be exercised not to violate due process. A violation of due process is not only detrimental to the proper discharge of the Board's duties, but would certainly work towards overturning any decision that the Board may desire to take as it relates to a pending case.

As it relates to the second incident as contained in the report, the Board would like to point out that this case also involved a unique set of circumstances that is not common in the practice of Dentistry in the State of West Virginia. Nevertheless, the Board has been exploring legal means to better address the circumstance in question which is a professional practicing in an impaired condition.

In that particular matter, it was brought to the attention of the West Virginia Board of Dental Examiners that there was an impaired practitioner engaging in business. After the information was received by the Office of the West Virginia Board of Dental Examiners, an investigation was directed and engaged on behalf of the West Virginia Board of Dental Examiners.

Initially, the investigator reported with a factual basis that the practitioner was exhibiting behavior of an impaired condition. The practitioner initially declined to release any records to the investigator concerning a medical condition for further examination and evaluation by the West Virginia Board of Dental Examiners. Based upon information

available, being the information as contained in the investigation and given the serious nature of the situation, the West Virginia Board of Dental Examiners instructed that the professional licensure should be immediately suspended and a hearing established to further address the same.

The West Virginia Board of Dental Examiners proceeded to summarily suspend the licensure of the professional, inadvertently assuming that such authority was available to the West Virginia Board of Dental Examiners. Thereafter, the licensee secured counsel and filed a response to the Board's complaint setting forth that the West Virginia Board of Dental Examiners had violated the licensee's due process by engaging a summary suspension of licensure when the Board had no such authority by statute. Immediately upon receipt of the same, the Board through the Executive Secretary, forwarded the information to counsel for the Board, to wit: the Attorney General's Office, for further legal advisory and consult.

After review and discussions with counsel as it related to the summary suspension, the Board was advised to reinstate the license, appropriately schedule a hearing in conformance with normal complaint procedures by engaging an amended complaint, and pursue the possibility of a Consent Decree as it related to the facts and circumstances of the case. Upon such advisory, the Board immediately engaged said circumstances pursuant to legal directive, and scheduled the matter for the Board's next meeting. (It should be noted the nine-member Board currently addresses any and all complaints. The Board does not have sufficient financial resources to convene on specific complaints, and, recognizing the same, has approached the legislature for fee increases, part of which would be used for purposes of scheduling hearings in between meetings to better move the complaint process as currently engaged by the West Virginia Board of Dental Examiners pursuant to law.) Therefore, a period of time passed before the hearing date was to transpire. Actions were being taken in the case in order to protect and ensure the safety of the public in the interim. Further investigation conducted by the Performance Evaluation and Research Division into the overall matter would have disclosed that during the course of additional difficulties being experienced in this particular matter, the licensee voluntarily discontinued practice for a period of thirty days or more and secured appropriate medical attention to further address such difficulties. Furthermore, there was an agreement between the licensee and the Board to continue the matter with certain factors in place, i.e. disclosure of information concerning the medical circumstances of the licensee in question for better review and evaluation by the Board for further disciplinary action, if any; appropriate testings to assure that the issue involved was not voluntary addiction; and that there was required to be in place an emergency procedure made knowledgeable to all persons on the staff and an appropriate licensed professional be on standby to assist in the event any circumstance would take place during the further prosecution of the proceeding as filed before the West Virginia Board of Dental Examiners.

As an end result, it should be noted this particular case involved an impaired practitioner of an involuntary nature. The facts clearly disclosed that the licensee in question was seeking appropriate medical attention for a medical condition from which the

individual suffered. During the course of the medical attention being received the licensee was given a variety of prescriptive medications for the condition which created occurrences that were taking place at the dental office, as noted in the Auditor's report. After full examination reports were given to the Board of Dental Examiners concerning the matter, the Board was made aware that the licensee in question was advised bythe physician that the regimen of prescriptive medication needed to be changed. The licensee was immediately taken off the regimen that previously existed, and all medications were re-modified to meet the medical condition. Thereafter, the circumstances being experienced in the work place were eliminated. When the information was finally disclosed to the Board and presented for finalization purposes, the Board agreed the Settlement Agreement in question would be an appropriate resolution to the case.

The Performance Evaluation and Research Division indicates the Board of Dental Examiners did not follow advise of their legal counsel in this case. The legal advisory in question, in the Board's opinion, would have been modified had counsel had an opportunity to review all the information for further answering of the concerns as set forth in counsel's letter. The Board had initially prepared a Consent Decree which was forwarded to the Attorney General's Office for review and submission to opposing counsel through the initial phases of the complaint process after the reinstatement of the license had been issued. After initial review of the same, counsel at the Attorney General's Office approved the Consent Decree as drafted by the Board, and the same was forwarded to opposing counsel for the licensee's consideration and review. Thereafter, the Board received a counter proposal which made the change from a Consent Decree to a Settlement Agreement with communication indicating the licensee's desire for the changes and rationales behind the same. This information was forwarded to the Attorney General's Office for review and advisory to the West Virginia Board of Dental Examiners. In the meantime documents were received by the Board and forwarded to the Attorney General which had not been reviewed when the Attorney General advised against the Settlement Agreement.

The Board vehemently, but respectfully opposes the opinion as set forth by the Auditor's Office that the public was not protected in the production of this case, and opposes any insinuation that this case was not properly handled by the West Virginia Board of Dental Examiners at the time in conformance with applicable law.

It should also be noted West Virginia does not currently have any form of remediation education. Other States employ such programs within their dental communities, including Maryland, Ohio, and Pennsylvania to name a few. Currently, the West Virginia Board of Dental Examiners is working with the West Virginia University's School of Dentistry to hopefully establish procedures for such matters, which will be instrumental in addressing matters as existing in the first case.

As it relates to the report indicating the Board does not require a licensee to report a serious incident at the time that it occurs, currently no such matter is in effect. In light of the first case and this Audit report, the West Virginia Board of Dental Examiners has

directed the Executive Secretary to engage inquiries into such reporting situations in other jurisdictions for further review and implementation of an appropriate procedure by the State of West Virginia, which the Board will further address when such information is received and present proposed legislation for proper promulgation to the Legislature of West Virginia for implementation as soon as possible.

Secondly, as it relates to the Board not requiring a licensee to report malpractice lawsuits at the time of filing against the practitioner, the Board of Dental Examiners does not currently require the same.

It is recommended in the Auditor's report that allegations of incidents in malpractice suits could be grounds for the Board to investigate to determine if actions are necessary. However, the Board will defer to legal counsel as to the legal issues concerning using filed matters in a separate and distinct tribunal for production of a complaint before the Board of Dental Examiners. In the event that the same is legally appropriate, then certainly the West Virginia Board of Dental Examiners will take such actions as necessary to invoke such procedures for future purposes if this Legislature so desires. The Board would request that this Legislature examine the cost factors and man power necessary to engage such action before a decision is finalized.

It is recommended that the Board require information about serious incidents and malpractice lawsuits be immediately forwarded to the Board members. To send the same immediately to Board members may violate open governmental meeting laws. Currently the entire Dental Board functions as the hearing body, being a nine-member Board, or at least did at the time of the initial filings. Only recently has the West Virginia Board of Dental Examiners engaged a two-member complaint review committee, but such members must also comply with open governmental meeting laws before any action can be taken concerning incidents. The rest of this matter will be deferred to the Boards legal counsel for further advisory.

Finally, as it relates to the issue of the Board conducting criminal background checks on all licensees, the same is currently not a process that is conducted by the Dental Board, and, to the Board's knowledge, no professional licensing entity does the same. Such requirement would impose an additional financial burden upon the Board, as well as man power to achieve the same. The West Virginia Board of Dental Examiners will defer to the Legislature of the State of West Virginia for further instructions to address this matter from a legal perspective.

In conclusion, the West Virginia Board of Dental Examiners would respectfully assert to this Honorable Legislature that the Dental Board does respond appropriately to all serious reports of malpractice and serious incidents in the practice of Dentistry as its authority allows.

The Board of Dental Examiners has currently engaged the process to obtain information concerning incident reporting in the practice of Dentistry in the State of West

Virginia which will effectively and appropriately, from a legal standpoint, enable the Board to develop procedures and rules on how to receive and disseminate such information to Board members for further review and consideration in order to protect the public safety.

The Board of Dental Examiners will require a criminal background check at the time of application for a dental licensure and periodically thereafter if required by this Legislature, but respectfully requests this Legislature take a close look at said issue as it relates to the cost aspects and man power involved in discharging the same before the implementation of laws directing that such matters be engaged.

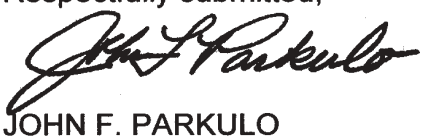
The Board of Dental Examiners will require all licensees to report malpractice lawsuits at the time of filing if the Legislature deem the same would be appropriate, whereas the Board is reluctant to consider the use of a separate and distinct action in order to engage it's authority in conformance with current and applicable laws.

The Board of Dental Examiners will defer to the Legislature concerning any considerations in requiring a professional licensed by Chapter 30 Boards to report malpractice lawsuits at the time of filing to the respective licensing boards, and will certainly follow any directives as set forth in law by this Honorable Legislature.

In closing, the West Virginia Board of Dental Examiners has at all times functioned in conformance with the laws currently at its disposal to effectively regulate the practice of Dentistry in the State of West Virginia, and has conformed to all proper procedures to ensure public safety. Furthermore, the West Virginia Board of Dental Examiners has always diligently promoted legislation of a continuing nature, as herein above set forth, to better develop proper procedures to ensure public safety and will continue to do the same. The process of oversight between renewal periods was not adequate but is being improved, the Dental Board is diligently working to make such additional improvements as deemed necessary by their findings on further examination into these matters, and will report such findings and make such proposed legislative changes, and will present the same to the Legislature as soon as possible.

Should any members of the Legislature have any questions, please do not hesitate to contact the Board of Dental Examiners for further addressing.

Respectfully submitted,



JOHN F. PARKULO
Executive Secretary

Enclosures

JOHN F. PARKULO

ANDERSON, PARKULO, STANSBURY & ASSOCIATES, L.C.
207 SOUTH HEBER STREET
BECKLEY, WEST VIRGINIA 25801
PHONE: (304) 252-0701
FAX: (304) 252-2779
E-MAIL: apsa@charterinternet.com

WEST VIRGINIA BOARD OF DENTAL EXAMINERS
207 SOUTH HEBER STREET
BECKLEY, WEST VIRGINIA 25801
PHONE: (304) 252-8266
FAX: (304) 253-9454
E-MAIL: wvbde@charterinternet.com

Education

Mississippi College School of Law
Doctor of Jurisprudence, May 1985

West Virginia University
Bachelor of Arts, May 1981
Major - Political Science
Minor - Public Administration, Business

Woodrow Wilson High School, Beckley, West Virginia
May 1977

Admissions to Practice

Admitted to the U.S. District Court for the Southern District of West Virginia
June 3, 1986

Admitted to practice by Supreme Court of Appeals of West Virginia
June 3, 1986

Legal Employment History and Concentration of Practice

Executive Secretary, West Virginia Board of Dental Examiners
Beckley, West Virginia, October 2003 - present

Assistant Executive Secretary, West Virginia Board of Dental Examiners
Beckley, West Virginia, October 1996 - October 2003

Anderson, Parkulo, Stansbury & Associates, L.C.,
Beckley, West Virginia, September 1989 - present

Primary areas of practice: Abuse and neglect, administrative law, contracts, criminal defense, domestic law, general civil litigation, landlord/tenant, personal injury, property law, real estate, and wills and estates.

Rist & Associates
Beckley, West Virginia, April 1989 through July 1989

Legislative Services, Bill Drafter
Charleston, West Virginia, 1989 Legislative Session

Assistant Prosecuting Attorney of Raleigh County
Beckley, West Virginia, June 1986 through December 1988

Professional Associations

American Bar Association
West Virginia Bar Association
West Virginia State Bar
Raleigh County (WV) Bar Association
American Association of Dental Examiners
West Virginia Association of Licensing Boards
Federation of American Regulatory Boards

Social and Civic Organizations

St. Francis deSales Catholic Church

Raleigh County Deputy Sheriff's Civil Service Commission, Member 1989 - 2001,
President 1991 - 2001
Beckley, West Virginia

Board of Directors, Beckley-Raleigh County Chamber of Commerce, 1994 - 1999
Beckley, West Virginia

Moot Court Board, Mississippi College School of Law, 1982 - 1985
Jackson, Mississippi

Secretary Student Body, Mississippi College School of Law, 1984 - 1985
Jackson, Mississippi

Delta Theta Phi Legal Fraternity, 1983
Jackson, Mississippi

Gamma Pi Chapter of Pi Sigma Alpha
National Political Science Honor Society, 1981

Board of Directors, Boy Scouts of America, Seneca District
Raleigh County, West Virginia

1975 Eagle Scout, Boy Scouts of America, Troop 1452
Beckley, West Virginia

Beckley Elks, Lodge #1452
Beckley, West Virginia

Beckley Moose, Lodge #1606
Beckley, West Virginia

Knights of Columbus, Council #5657, 4th Degree
Beckley, West Virginia

WEST VIRGINIA BOARD OF DENTAL EXAMINERS
207 S. HEBER STREET
BECKLEY, WV 25801
(304) 252-8266
Toll Free (877) 914-8266
FAX (304) 253-9454
www.wvdentalboard.org
wvbde@charterinternet.com

August 29, 2005

West Virginia Board of Dental Examiners
207 South Heber Street
Beckley, WV 25801

Dear Members of the Board:

Based upon the preliminary reports of the Legislative Audit, the undersigned hereby surrenders his resignation to this Board, should the Board deem such action necessary to have better Executive guidance in light of said report.

Respectfully Submitted,

JOHN F. PARKULO
Executive Secretary

JFP/smc
cc: John Sylvia, Performance Evaluation and Research Division
Darlene Ratliff - Thomas, Attorney General's Office

JOHN F. PARKULO
180 MINK CROSSING
DANIELS, WV 25832
(304)763-5255

September 6, 2005

Ms. Gail V. Higgins, MPA
Office of the Legislative Auditor
Performance Evaluation & Research Division
Building 1, Room W-314
1900 Kanawha Blvd., East
Charleston, WV 25305-0610

RE: Regulatory Board Review of the Board of Dental Examiners

Dear Ms. Higgins:

In light of this report, the undersigned, personally would like to respond and, attaches hereto the undersigned's curriculum vitae for purposes of informing the members of Legislature of the qualifications of the undersigned to effectively discharge the duties as Executive Secretary for the West Virginia Board of Dental Examiners.

The undersigned has been a licensed, practicing attorney for nineteen years, and has been an employee of the Board for approximately nine years - initially as Assistant Executive Secretary, and, effective October 1, 2003, as the Executive Secretary for the West Virginia Board of Dental Examiners.

The undersigned submits that he is qualified to discharge the duties as Executive Secretary, and, at all times in said employment, has effectively discharged said duties to the best of his abilities and in conformance with his responsibilities as required by the position with the West Virginia Board of Dental Examiners.

Furthermore, it should be noted that as an employee of the West Virginia Board of Dental Examiners, the undersigned vehemently, but respectfully, disagrees with the findings of the Performance Evaluation and Research Division as set forth in the preliminary report.

In the undersigned's nine-year tenure with the West Virginia Board of Dental Examiners, he has had the distinct privilege and pleasure of working with some of the most knowledgeable, professional, and dedicated individuals as assigned to the position of

Board Members of the West Virginia Board of Dental Examiners by the Governor of the State of West Virginia. Not only current Board Members, but past Board Members as well have worked diligently, investing large amounts of time, and have appropriately followed, to the best of their abilities, instructions as given to them by this Executive Secretary and their Legal Counsel in the proper discharge of their duties as set forth by statute. While the undersigned agrees that the fundamental purpose of licensure and registration is to protect the public, the undersigned would submit the same must take place according to proper legal authority and in conformance with due process of law in order to effectively protect the public as asserted in the Auditor's report.

It should be noted that the error in sending the Summary Suspension Order in the one case was the responsibility of the undersigned, as Executive Secretary. However, the same was done in good faith and certainly not intentionally to violate the due process rights of the licensee in question.

While I am not counsel for the Board of Dental Examiners, I am a licensed practicing attorney of nineteen years experience. The resolution, given the facts and circumstances of the impaired practitioner case, in the undersigned's opinion was appropriately addressed and appropriately handled in conforming with the laws of the State of West Virginia. Recognizing the undersigned erred in doing the summary suspension of the practitioner's license, to which the undersigned takes full responsibility, the Board of Dental Examiners was also advised for the need of summary suspension laws for circumstances of such nature. Again, initially the Legislature refused to grant summary suspension to the Dental Board upon their request in the 2005 Legislative Session. However, after the fact, I have learned that all Chapter 30 Boards did, in fact, receive summary suspension powers and in that respect, and on behalf of the Board of Dental Examiners, I sincerely appreciate the Legislature for a much needed tool to better address such circumstances. Recognizing the error which occurred in the due process of the licensee in question, the undersigned, not the West Virginia Board of Dental Examiners, expects to be held fully accountable for the error that was engaged.

The Board, recognizing the need for changes, has already made changes to the license renewal application which sets forth a questionnaire concerning any impaired conditions, and the same was added to the license renewal process. The West Virginia Board of Dental Examiners is also diligently working to implant some type of rehabilitative services for impaired practitioners that submit their situation from a voluntary standpoint, and the Board is desirous of implementing such legislation as soon as the same can be reviewed and developed by the Board for implementation in the State of West Virginia. Various States throughout the country have some form of law as it relates to impaired practitioners, and the State of West Virginia is currently disseminating that information for further production of proposed legislation to be presented to this Honorable Legislature to further address that issue.

In the undersigned's opinion, in no way did the Board's discharge of it's duties as it relates to the two cases indicated in the Audit Report place the public at risk. In converse, the Dental Board has always performed its designated and delegated responsibilities in protecting the public. The undersigned assumes full responsibility for

such alleged actions or inactions relating to the failure to protect the public safety surrounding these two cases as alleged in the Audit. Therefore, the undersigned has surrendered his resignation, as attached, to the West Virginia Board of Dental Examiners in light of said Audit report so they may take such action as they deem necessary in light of these circumstances.

As always, should any member of the Legislature have questions as they relate to these comments as asserted by the undersigned personally, I'll be happy to address the same at the Legislature's convenience.

Respectfully submitted,

JOHN F. PARKULO
Executive Secretary

Enclosures