STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF DENTAL EXAMINERS

In re: WILLIAM MCDONALD, D.M.D. License No. 016.0000689	} } }	Docket No. 2019-77

Appearances:

Prosecuting the case: Traci Leibowitz, Esq.
Respondent: the Respondent participated in the hearing, *pro se*

Appellate Officer: George K. Belcher

FINDINGS AND ORDER REGARDING MOTION TO DISMISS APPEAL

The Appellate Officer of the Vermont Board of Dental Examiners held a hearing pursuant to 3 VSA Sec. 130a in the above matter on June 17, 2020. The hearing was to consider the State's Motion to Dismiss the appeal of Dr. McDonald.

Findings of Fact

1. A contested disciplinary case was decided by the Vermont Board of Dental Examiners regarding charges against the Respondent. The Respondent was represented in the case by counsel and testified before the Board at the hearing on February 12, 2020. The Board found that two of the charges of unprofessional conduct had been proven. After reciting a history of the Respondent's professional discipline, the Board made the decision to revoke the license of the Respondent. That order was entered on February 19, 2020. The Respondent filed a notice of appeal with the Office of Professional Regulation on March 9, 2020. His notice of appeal contained the following statement, "Please inform me if I am required to include any documents with this appeal."
2. On April 3, 2020 the Docket Clerk for the Office of Professional Regulation wrote to Dr. McDonald. That letter informed Dr. McDonald that he "must within ten days send a statement of questions to be determined by the Appellate Officer". The letter also advised that the Respondent must make arrangements to obtain a transcript of the hearing and that the cost was estimated to be $780.00. This letter was sent to Dr. McDonald by certified mail and was received and signed for by "K. O'Hara". (The date of receipt was not apparent from the record since the date-of-receipt box was not completed by K. O'Hara.)
3. No transcript was ordered by Dr. McDonald and no statement of questions was filed within the time frame set forth in the April 3, 2020 directive.
4. Dr. McDonald testified at the hearing on the Motion to Dismiss the Appeal that he had requested from Attorney Leibowitz, by email, the original complaint letter which formed

the basis for the specification of charges, and that he also requested from her that there be a waiver of the transcript. Dr. McDonald testified that he received no response to these requests and that this caused him to delay further action with the Board. He further testified that he eventually filed questions for determination with the Board on May 17, 2020 (after the Motion to Dismiss the Appeal dated April 22, 2020 had been filed).

5. Attorney Leibowitz represented to the Appellate Officer on the record that she did in fact respond to Dr. McDonald's communications on March 5th, March 11th, and May 28th.
6. In argument, Dr. McDonald testified that part of his appeal would be based on the original letter of complaint to OPR (which had been received by his office before the merits hearing occurred but was probably thrown away by staff). He had been asking Ms. Leibowitz for a copy of that complaint letter after filing his notice of appeal. He also stated that there was no need for him to request a transcript because the findings and order of the Board were flawed on their face.
7. The original complaint letter could have been discovered by the Respondent at, or prior to, his original hearing in February of 2020. Moreover, the availability of this letter and its relevance to the facts of this case, go to the merits hearing conducted below rather than the appeal.
8. The Appellant's request for waiver of the transcript was puzzling given that the hearing was three hours long. There were five pages of Findings of Fact in the order below. A transcript was clearly a necessity.
9. The Respondent conceded that the statement of questions was filed late, but argued that this was because he was waiting for more information from Attorney Leibowitz.
10. The Motion to Dismiss the Appeal was dated 22 April, 2020. Notice of the hearing on the motion and a copy of the motion was sent to Dr. McDonald on May 1, 2020. Dr. McDonald sent an email to the OPR Docket Clerk on May 22, 2020 which included a copy of his letter to Attorney Leibowitz dated May 17, 2020. That letter contained a request for waiver of the transcript, information about the complaint letter which he alleged constituted evidence tampering, and factual disagreements with the facts as found by the Board of Dental Examiners.

Conclusions of Law

1. Appeals from Board decisions are taken first to an Appellate Officer under 3 VSA Sec. 130a. These appeals are "...to be conducted on the basis of the record created before the board." Id. Thus, a transcript of the evidence presented below is essential. It is unlikely that a waiver of the transcript would be granted where extensive evidence was presented below.
2. The time period within which an appellant should file with the Docket Clerk an order of the transcript is within ten (10) days after filing the notice of appeal. OPR Rule 4.2.
3. Likewise, the Administrative Rules of the Office of Professional Regulation, require that "The Notice of appeal shall include a statement of questions to be determined by the Appellate Officer." OPR Rule 4.1 One would assume that Mr. McDonald did, or should have, checked this rule before filing his notice of appeal.
4. The decision on the Motion to Dismiss the Appeal is most cogently addressed by the

Vermont Supreme Court case of In re Joyce, 2018 VT 90, 197 A.3d 378 (Vt. 2018). In that case, the Vermont Supreme Court was presented with similar facts where a transcript was not ordered but a waiver was requested. Likewise, a statement of questions was not filed because, as argued by the appellant in that case, the appellant's notice of appeal gave certain legal arguments and alleged factual contradictions to the findings. (No separate statement of questions was ever filed as such.)

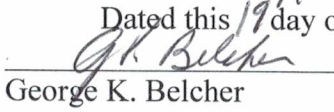
5. In the Joyce case the Vermont Supreme Court evaluated: (1) the purpose and function of the administrative appeal process; (2) the importance of a transcript to that process; (3) the importance of procedural requirements to the appeal process; (4) and the ability of administrative agencies to create procedural rules and then to apply them. That case (under facts more favorable to the appellant than those now before us) strongly urge in favor of dismissal of this appeal for (1) failing to order a transcript, and (2) failure to file a timely statement of questions.
6. Vermont Rule of Appellate Procedure 42(b) permits dismissal of an appeal in which a party has not complied with a filing deadline. That rule of procedure is incorporated into the Administrative Rules of the Office of Professional Regulation (See Administrative Rule of OPR 2.4.)
7. It is appropriate to quote a section from the Joyce case which is applicable to the case at bar.

> In his final order dismissing Joyce's appeal, the appellate officer wrote that the statement of questions and transcript requirements " are not a matter of form over substance," rather, "[t]hey are designed and required to see that appellate issues governed through the Office of Professional Regulation are grounded in due process and focused analysis of the facts under law." Although we note that Joyce's position as a *pro se* appellant, the Administrative Rules of Practice state that "anyone appearing *pro se* shall be under all the obligations of an attorney admitted to practice in this state with respect to the matter in which such person appears" Administrative Rules of Practice Sec. 3.1(b), Code of Vt. Rules 04 0303 005, https://www.lexixnexis.com/hottopics/michie. This includes ordering a transcript and filing a statement of questions, without which neither we nor the appellate officer can properly evaluate the merits of Joyce's case. Supra at paragraph 27.

8. In this case the failure of the appellant to properly order a transcript or to file a timely statement of questions, support the dismissal of the appeal.

The Appeal of William McDonald in this case is hereby **DISMISSED**.

Dated this 19th day of June, 2020.



George K. Belcher
Appellate Officer

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 6/24/2020

APPEAL RIGHTS

This is a final administrative determination by the appellate officer. 3 V.S.A. §130a. A party aggrieved by the decision of an appellate officer may appeal to the Vermont Supreme Court which shall review the matter on the basis of the records created before the board or administrative law officer and the appellate officer. A party may appeal a decision of an appellate officer to the Vermont Supreme Court by filing with the Docket Clerk a written notice of appeal within 30 days of the date of entry of the order, in the manner provided in the Vermont Rules of Appellate Procedure 3 and 4. A check for the court filing fee, made payable to the Clerk of the Vermont Supreme Court, must accompany the filing.

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF DENTAL EXAMINERS

In re: WILLIAM McDONALD, D.M.D. **Docket No. 2019-77**
License No. 016.0000689

FINAL ORDER
DECISION ON UNPROFESSIONAL CONDUCT

Board of Dental Examiners:
Robert Ruhl, Chair
David Baasch
Mimi Kevan
Linda Greaves
Lucille Kelly
Jennie Kendall
William Koch
Randall Miller
Elizabeth Merrill

Appearances:
Prosecuting Attorney: Traci Leibowitz, Esq.
Respondent: L. Brooke Dingledine, Esq. for Respondent
Respondent William McDonald, D.M.D. personally appeared

Presiding Officer: Michael S. Kupersmith, Esq., Administrative Law officer

Introduction

On or about June 7, 2019, the State filed a Specification of Charges against the Respondent, William McDonald, D.M.D. The Respondent, then representing himself, filed his Answer on June 17. A discovery schedule was issued and a contested hearing set for November 13, 2019. On September 30, while Respondent was still self-represented, the parties submitted a Stipulation and Consent Order. The Board of Dental Examiners reviewed the Stipulation and rejected it. Respondent then retained Attorney L. Brooke Dingledine, who requested a ninety-day continuance so that she could prepare the defense.

A contested hearing was conducted by the Board on February 12, 2020 at the Office of Professional Regulation, 89 Main Street, Montpelier, Vermont. The State was represented by Traci Leibowitz, Esq. The Respondent was present (for the merits portion of the hearing) and was represented by L. Brooke Dingledine, Esq. Based upon the pleadings and the credible evidence presented, the Board finds that the State has proved the following facts by a preponderance of the evidence.

Findings of Fact

1. William McDonald of Rutland, Vermont is licensed by the State of Vermont as a Dentist under license no. 016.0000689. The license was originally issued on May 1, 1980 and expires on September 30, 2021.

2. The Respondent works at a dental office in Rutland, Vermont, and has a satellite office in Woodstock, Vermont.

3. The Board of Dental Examiners has disciplined Respondent on nine (9) prior occasions. Respondent's history of discipline dates back to 2003 when four cases were resolved by stipulation and sanctions were imposed. The Board again sanctioned Respondent in July 2005, June 2006, October, 2007, September, 2013, and January, 2015.

4. The complaint which triggered this proceeding was filed by M.T. in October, 2018. He had visited the Respondent in his Woodstock office for examination and treatment. He complained that various parts of the examination room were dusty, dirty, and appeared to be smeared with dried blood and dried bodily fluids. He also complained, "I did not notice a clean tray of tools that had been sealed and sanitized. Instead, all of the tools he needed were piled up on a counter next to where he sat." See Respondent's exhibit *A*. M.T. was so concerned about unsanitary conditions in the Respondent's office and the manner in which he kept his dental instruments, that he had himself tested for both HIV and hepatitis that evening.

5. Subsequent to the filing of the complaint, Investigator Dennis Menard of the Office of Professional Regulation (OPR) sent an email to the Respondent to which he attached M.T.'s letter of complaint. Mr. Menard advised the Respondent that OPR had received the complaint and that he was conducting an investigation. He asked the Respondent to respond to M.T.'s allegations. The Respondent transmitted an email reply to Mr. Menard's inquiry on February 15, 2019. The reply was admitted into evidence as State's exhibit #1.

6. For purposes of this proceeding, the pertinent portions of the reply are as follows:

   ¶ 3. Hand pieces are washed with a solution of chlorhexadine gluconate, the active ingredient in surgical soaps, followed by being wiped with the above mentioned Cavicide. If a patient has a history of hepatitis, the hand piece is run through the dry heat sterilizer at 325F for one hour.

   ¶ 4. Metal instruments that are reused are washed in chlorhexadine gluconate, rinsed and placed in the dry heat sterilizer for one hour at 325F.

   ¶ 5. Instruments are removed from the sterilizer with gloved hands and either placed in instrument bags or in trays with locking tops for clean storage.

   ¶ 6. Instrument trays used while treating patients are washed following use with

chlorhexidine gluconate followed by being sprayed with Cavicide.

¶ 7. The instrument treatment trays are prepared by removing instruments from storage trays with gloved hands and assembled as needed on treatment trays.

7. In the Respondent's email response (exhibit #1), the Respondent advised Mr. Menard, "I will have my lead clinical assistant write you a letter explaining our policies and procedures as I expect them to be employed so that you will have an opinion from someone other than myself." Mr. Menard never received such a letter.

8. In Defendant's Answer, he did not dispute, and thus admitted, the accuracy of the allegations in paragraphs 11, 12, and 13 of the Specification of Charges. They read as follows:

   ¶ 11. Respondent's practice is to heat sterilize intraoral handpieces only after use on a patient with a history of hepatitis.

   ¶ 12. After use on a patient with a history of hepatitis, Respondent runs the handpiece through the dry heat sterilizer at 325 degrees for 1 hour.

   ¶ 13. After use on a patient with no history of hepatitis, Respondent washes the handpieces with a solution of chlorhexadine gluconate, the active ingredient in surgical soap, then wipes the pieces with Cavicide.

9. The Respondent testified that his office takes a medical history from all patients, and asks all returning patients if there have been any recent medical changes. He testified that he takes patients at their word concerning their medical histories and that he only checks with their physicians if they report a serious condition.

10. The Respondent testified that since the Specification of Charges was filed, he has changed his office protocols. He stated that he did so because, "My interests, political and professional, are served with heat sterilization." He believes that heat sterilization is the "best practice" as opposed to minimum acceptable standards. He stated that he had not been using heat sterilization previously because, "I wasn't trained to do so." Respondent testified that he received his dental education at Tufts Dental School, where he graduated in 1975.

11. Although the Respondent has changed his office protocols, the following deficiencies are noted:

    a. Respondent heat-sterilizes all detachable instruments. However, instruments are not bagged before being placed in the heat sterilizer, but rather are bagged after purported sterilization has been completed. The effective standard practice is to place instruments in bags before sterilization. These bags have post-sterilization indicators which show whether the instruments have in fact achieved sterility.

b. The Respondent does not use other techniques to make certain that his heat sterilizer is working properly, by using, for example, sterilization strips and periodic spore testing.

c. Respondent is aware that internal parts of some non-detachable instruments may harbor microbes because of retraction of fluids from patients' mouths. Consequently, he does not shut off the device while it is in a patient's mouth and he runs it for 15 or 20 seconds after the patient is discharged.

d. Respondent does not use universal precautions in treating patients. He does not treat every patient as if the patient had HIV, hepatitis, or other infectious disease.

12. The Centers for Disease Control and Prevention ("CDC") is a component of the United States Department of Health and Human Services. In 2003, CDC published a report entitled "Guidelines for Infection Control in Dental Health-Care Settings—2003." The report was admitted into evidence as Respondent's exhibit *B*. A supplement to the report was published on April 11, 2018 and is entitled "CDC Statement on Reprocessing Dental Handpieces." The supplement was admitted into evidence as State's exhibit #2.

13. The pertinent sections of Respondent's exhibit *B*, is found on page 30 under the heading "Special Considerations."

> Multiple semicritical dental devices that touch mucous membranes are attached to the air or waterlines of the dental unit. Among these devices are high- and low-speed handpieces, prophylaxis angles, ultrasonic and sonic scaling tips, air abrasion devices, and air and water syringe tips. Although no epidemiologic evidence implicates these instruments in disease transmission, studies of high-speed handpieces using dye expulsion have confirmed the potential for retracting oral fluids into internal compartments of the device. This determination indicates that retained patient material can be expelled intraorally during subsequent uses. Studies using laboratory models also indicate the possibility for retention of viral DNA and viable virus inside both high-speed handpieces and prophylaxis angles. The potential for contamination of the internal surfaces of other devices (e.g., low-speed handpieces and ultrasonic scalers), has not been studied, but restricted physical access limits their cleaning. *Accordingly, any dental device connected to the dental air/water system that enters the patient's mouth should be run to discharge water, air, or a combination for a minimum of 20--30 seconds after each patient.* This procedure is intended to help physically flush out patient material that might have entered the turbine and air and waterlines.
>
> Heat methods can sterilize dental handpieces and other intraoral devices attached to air or waterlines. *For processing any dental device that can be removed from the dental unit air or waterlines, neither surface disinfection nor immersion in chemical germicides is an acceptable method.* Ethylene oxide gas cannot adequately sterilize internal components of handpieces. In clinical evaluations of high-speed handpieces, cleaning and lubrication were the most

critical factors in determining performance and durability. Manufacturer's instructions for cleaning, lubrication, and sterilization should be followed closely to ensure both the effectiveness of the process and the longevity of handpieces.

Some components of dental instruments are permanently attached to dental unit waterlines and although they do not enter the patient's oral cavity, they are likely to become contaminated with oral fluids during treatment procedures. *Such components (e.g., handles or dental unit attachments of saliva ejectors, high-speed air evacuators, and air/water syringes) should be covered with impervious barriers that are changed after each use.* If the item becomes visibly contaminated during use, [Dental Health Care Personnel] should clean and disinfect with an EPA-registered hospital disinfectant (intermediate-level) before use on the next patient.

(Emphasis added; footnotes omitted.)

Conclusions of Law

The Board concludes that the State has proved Violation One and Violation Two by a preponderance of the evidence. Respondent is first charged with violating 3 V.S.A. § 129a(b)(1). That section provides:

> **(b)** Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:
> **(1)** performance of unsafe or unacceptable patient or client care;

The Violation Two alleges that Respondent violated 3 V.S.A. § 129a(b)(2) which provides:

> **(b)** Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:
> ***
> **(2)** failure to conform to the essential standards of acceptable and prevailing practice.

The Board of Dental Examiners employs its collective experience and expertise in determining that the CDC Morbidity and Mortality Weekly Report, Respondent's exhibit *B*, has established the minimum safe and acceptable standard of patient care in Vermont with respect to sanitizing dental instruments and equipment used directly on patients. The report was published in December 2003, and has been the established standard of care since that time.

The evidence is clear that at the time of M.T.'s complaint—and at least until February 15, 2019—the Respondent's office protocol for sterilizing dental instruments did not meet the minimum safe and acceptable standard of patient care. He did not use heat sterilization methods to sterilize his dental instruments except in cases where the patient self-reported a history of HIV or hepatitis infection.

The problem with relying on a patient's self-report is obvious. A patient may simply not be aware that he or she is infected with a serious infectious disease such as HIV or hepatitis. As well, even if a patient is aware of an infection, he or she may not share the information with a dentist out of embarrassment or concern that the dentist may refuse treatment or some other reason. The only acceptable practice is to handle every patient as if the patient were infected.

The Board concludes that the evidence that the Respondent failed to abide by sterilization standards established by the CDC constitutes a sufficient factual basis to support both Violation One and Violation Two. The Board concludes that the Respondent failed to practice competently by the performance of unsafe and unacceptable patient care *and* that he failed to practice competently by failing to conform to the essential elements of acceptable and prevailing practice.[1]

The Board notes that although it was the complaint of M.T. in October 2018 that brought the Respondent's unprofessional conduct to the attention of OPR, based upon the Respondent's statements to Investigator Menard, his Answer to the Specification of Charges, and his testimony at hearing, it is reasonable to infer that the Respondent has been treating all his patients since December, 2003 and at least until February 2019, without employing the necessary sterilization protocols.

Sanction

As indicated in the Short Order issued by the Board on February 13, 2020, the Board has determined that under the totality of the circumstances, the only appropriate sanction is revocation of the Respondent's license to practice dentistry. The Board's determination is based upon the following reasons:

1. The Respondent's long-standing employment of unsafe and unacceptable practices.

The CDC standards were published in December 2003. As of February 2019, over fifteen years later, the Respondent was still using unsafe and unacceptable sterilization protocols. The Respondent testified that he has been required to participate in numerous hours of continuing professional education every two years, yet he failed during that fifteen-year period to learn of the minimum acceptable sterilization practices. Apparently, as he testified, he continued to use outdated methods because that was the way he "was trained" at Tufts Dental School in the early 1970's.

2. The Respondent's continued use of unsafe and unacceptable practices.

After the complaint was filed, the Respondent changed some of his protocols. Although he did not testify about the cause of his modifications, it is reasonable to infer that he believed that at least some of his practices were substandard. He did not, however, either learn what the minimum safe standards were or else he failed to implement them. The current deficiencies are

[1] The Board wishes to note with respect to Violation Three, the State proved that the Respondent utilized poor professional judgment, it did not establish that he failed to use *independent* professional judgment.

set forth in paragraph 11 of the findings of fact. The Board concludes that the Respondent is not capable of adopting safe practices even when the need is called to his attention.

3. Record of Disciplinary Proceedings.

The Respondent has been the subject of disciplinary proceedings nine times as outlined in paragraph 3 of the findings of fact. A summary of the unprofessional conduct charges and orders follows:

a. The first four charged were heard and decided together on December 12, 2003 in docket numbers DE41-0401, DE15-0202, DE16-0202, and DE24-0402. In summary, the charges included: being bitten by a special needs patient and failing to adequately document the incident; inserting an incorrectly fitting denture into the mouth of a patient; and performing restorative work without taking, reviewing and documenting pre-treatment x-rays. The order included a reprimand and conditions placed on Respondent's license.

b. Docket no. DE11-1204. The Respondent was charged with failing to comply with a condition of the Board's order issued on December 12, 2003. Respondent had been ordered to "enroll in and successfully complete the 'Simulated Patient Clinical Exercise' as offered by NERB (North East Regional Board) at the next opportunity." Six months after the order issued, the Respondent asked to be exempted from this requirement, a request that the Board denied. The Respondent failed to enroll in the next available session—he missed the deadline—and did not enroll until the April. 2005 session. He failed the post-course examination by a significant margin. The Board suspended Respondent's license for 44 days, but "suspended" 30 of the 44 days provided he successfully complete the course by August 21, 2005.

c. Docket no. DE06-0904 entered on June 26, 2006. The Respondent made a model of a patient's mouth for a determination of whether she was entitled to Medicaid assistance for orthodontia. Respondent did not submit the model for Medicaid evaluation, but made his own determination that she was not eligible. Respondent then had the model discarded after an angry phone call from the patient's father. The Board determined that the Respondent had failed to conform to the essential standards of acceptable and prevailing practice by discarding the model. The Board placed a Warning on Respondent's license.

d. Docket no. DE02-0708 entered on October 15, 2007. The Board determined that the Respondent should have advised a patient that a particular tooth (#19) needed restoration as soon as possible, but there was no evidence in the patient's records that he did so. The Board also determined that when the patient returned to his office because of "killing pain" in another tooth (#18), he made her sign a promissory note before he would extract the tooth. Both instances were deemed unprofessional conduct. The Board ordered that Respondent pay two civil fines of $1000 each and that he complete three pre-approved rehabilitative courses. The Board imposed a 90-

day suspension, but "suspended" it as long as the Respondent complied with the order.

e. Docket no. 2012-252 entered on September 11, 2013. It was alleged that the Respondent had used a gloved hand to move a garbage can while treating a patient and that he had subsequently returned the gloved hand to the patient's mouth. The Respondent claimed that he had washed the glove before returning it to the patient's mouth. In a Stipulation submitted to the Board, Respondent admitted that his conduct failed to comply with federal or state statute or rules governing the practice of dentistry and that he failed to practice competently by failing to conform to the essential standards of acceptable and prevailing practice. The Board Warned Respondent's license and ordered him to pay a civil fine of $500 within sixty days.

f. Docket no. 2013-603 entered on January 30, 2015. The Board determined that the Respondent failed to conform to the essential standards of acceptable and prevailing dental practice by extracting the tooth of a minor patient without the use of pre-extraction x-rays and without obtaining the consent of the patient's mother. The Board's order suspended the Respondent's license for six months and conditioned reinstatement on completion of a pre-approved course in "risk management."

The last sixteen years of the Respondent's practice demonstrate chronic disregard for the health, safety and welfare of his patients. Despite repeated and escalating sanctions imposed by the Board of Dental Examiners, the Respondent has consistently failed to conduct his practice with the interests and welfare of his patients at the forefront. In this case, he failed to adopt basic protocols of heat sterilization of his instruments for fifteen years after they had been established by the CDC. He recognized that some sort of heat sterilization was appropriate when a patient self-reported a history of HIV or hepatitis infection, but astoundingly failed to recognize that such precautions were necessary for all patients because of the *possibility* that a patient might carry an infectious disease and be unaware of it or might conceal it.

Respondent's cavalier attitude toward cleanliness emerged (as of record) as early as 2012, when he used a gloved hand to move a trash can in in examination room and then returned to the patient's mouth with the same glove—whether or not he washed it. His attitude is also evident in his current protocol in the use of non-detachable instruments that may retract fluids from patients' mouths. He testified that he runs them for only 15 or 20 seconds to clear them after use on a patient and not the 20 to 30 seconds established by the CDC.

Respondent's unprofessional attitude was perhaps best summarized by his comment during his testimony about the reasons he modified his sterilization protocol after the instant complaint was filed. He did so because, "my interests, political and professional, are served with heat sterilization." He did not mention that the health, safety, and welfare of his patients require heat sterilization.

It is for these reasons, that the Board unanimously concludes that revocation of Respondent's license is required.

ORDER

The license of Respondent William McDonald to practice dentistry is ***revoked.***

Dated at Montpelier, Vermont, this 12TH day of February, 2020,

Board of Dental Examiners
By: Robert Ruhl, Chair

Date of Entry: 2.19.2020

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Dental Examiners. A party aggrieved by a final decision by the Board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Office of Professional Regulation, 89 Main St., 3rd floor, Montpelier, VT 05620-3402, within 30 days of the entry of this Order. If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an Appellate Officer. The review shall be conducted on the basis of the record created before the Board. In cases of alleged irregularities in procedure before the Board, not shown in the record, proof on that issue may be taken by the Appellate Officer. 3 V.S.A. §§ 129(d) and 130a. A stay may also be requested.

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STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF DENTAL EXAMINERS

IN RE: WILLIAM McDONALD, D.M.D.
License No. 016.0000689

Docket No. 2019-77

SHORT ORDER

On February 12, 2020, the Board of Dental Examiners conducted a final hearing on the Specification of Charges filed in the instant proceeding. Upon reviewing the pleading, the evidence presented, and the argument of the parties, the Board concluded that the State had proved by a preponderance of the evidence the first two violations alleged, to wit: (1) the Respondent failed to practice competently by the performance of unsafe and unacceptable patient care; and (2) the Respondent failed to practice competently by failing to conform to the essential standards of acceptable and prevailing practice.

The Board concluded that despite the filing of the Specification of Charges and the Respondent's post-charge recognition of the need to sterilize his dental instruments, the Respondent continues to utilize some instruments on patients that are not sterilized. The Board concluded that because of the circumstances of this case, and because of the Respondent's history of multiple adjudications of unprofessional conduct, revocation of the Respondent's license to practice dentistry was the only appropriate sanction. The Board further concluded that the health, safety, and welfare of the public imperatively requires immediate action.

Accordingly, it is hereby ORDERED that the Respondent's license to practice dentistry is revoked as of 4:30 p.m. on February 12, 2020.

R S Ruhl, DMD

Board of Dental Examiners, by:
Robert Ruhl, Chair

Date of Entry: 2 · 13 · 2020

Note: This is not a final order of the Board of Dental Examiners. The Board will expeditiously issue a comprehensive final order setting forth findings of fact, conclusions of law, and the sanction referenced above.

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STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF DENTAL EXAMINERS

IN RE:	)	
William McDonald	)	**Docket No.** 2019-77
License No. 016.0000689	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, William McDonald:

Authority

1. The Vermont State Board of Dental Examiners (the "Board") has jurisdiction to hear matters involving allegations of unprofessional conduct committed by dentists, dental hygienists, and dental assistants pursuant to 3 V.S.A. §§127, 129, 129a; 26 V.S.A. Chapter 12; the Administrative Rules of the Board of Dental Examiners ("ARBDE"); and the Rules of the Vermont Office of Professional Regulation ("OPR").

Statement of Facts

2. William McDonald ("Respondent") of Rutland, Vermont is licensed by the State of Vermont as a Dentist under license number 016.0000689. This license was originally issued on May 1, 1980, and expires on September 30, 2019.

3. Respondent works as a Dentist at a dental office located in Woodstock, Vermont.

4. The Board has disciplined Respondent on nine prior occasions. Respondent's history of discipline dates back to 2003 when four separate dockets were resolved by stipulation and sanctions were imposed. The Board again sanctioned Respondent in July 2005, June 2006, April 2008, and September 2007. The Board's most recent imposition of sanctions against Respondent occurred on January 30, 2015.

5. On October 26, 2018, Complainant visited Respondent's practice seeking to repair a filling in a molar.

6. When Complainant arrived, Respondent recently finished treatment of another patient. Respondent did not take any noticeable amount of time to clean and sanitize the exam room before bringing Complainant back for treatment.

7. No support staff, dental assistants, or dental hygienists were present during Respondent's treatment of Complainant.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
05620-3402

8. Respondent's office was in an unsanitary condition. The dental operatory light and ceiling were visibly soiled and the tools used by Respondent appeared in a state of disarray.

9. Respondent performed a pulpectomy on Complainant. It was the first of a series of procedures needed to remedy Complainant's dental issue.

10. Because of the unsanitary conditions, Complainant never returned to Respondent's office for follow up care. Complainant sought HIV and Hepatitis testing at Urgent Care the same day of his October 26, 2018 visit with Respondent.

11. Respondent's practice is to heat sterilize intraoral handpieces only after use on a patient with a history of hepatitis.

12. After use on a patient with a history of hepatitis, Respondent runs the handpiece through the dry heat sterilizer at 325 degrees for 1 hour.

13. After use on a patient with no history of hepatitis, Respondent washes the handpieces with a solution of clorhexadenegluconate, the active ingredient in surgical soaps, then wipes the handpieces with Cavacide.

Violation One: 3 V.S.A §129a(b)(1) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care.

14. The State re-alleges and incorporates Paragraphs 2 through 13 above.

15. As a Dentist, Respondent is required to provide safe and acceptable patient or client care.

16. Paragraphs 2 through 13 demonstrate that Respondent failed to practice competently and performed unacceptable patient care when he failed to heat sanitize handpieces after use on each individual patient.

17. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Two: 3 V.S.A §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

18. The State re-alleges and incorporates Paragraphs 2 through 13 above.

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19. As a Dentist, Respondent is required to conform to the essential standards of acceptable and prevailing practice for Dentists.

20. According to the Centers for Disease Control and Prevention (the "CDC") and the Federal Food and Drug Administration (the "FDA"), handpieces should be cleaned and heat-sterilized between each patient use, regardless of the patient's medical history.

21. Paragraphs 2 through 13 demonstrate that Respondent failed to practice competently and failed to conform to the essential standards of acceptable and prevailing practice by implementing a practice of heat-sterilizing handpieces only after use by a patient with a history of hepatitis.

22. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Violation Three: 3 V.S.A. §129a(a)(15) Failure to exercise independent professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession.

23. The State re-alleges and incorporates Paragraphs 2 through 13 above.

24. As a Dentist, Respondent is required to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

25. Paragraphs 2 through 13 demonstrate that Respondent failed to exercise independent professional judgment in the performance of licensed activities when that judgment was necessary to avoid action repugnant to the obligations of the profession. Respondent did this by implementing a practice in his office of heat-sterilizing handpieces only after use by a patient with a history of hepatitis.

26. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Relief Requested

WHEREFORE, the license of William McDonald should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
89 Main Street
3rd Floor
Montpelier, VT
05620-3402

DATED at Montpelier, Vermont this 7th day of June, 2019.

STATE OF VERMONT
SECRETARY OF STATE

By: _____

Traci Leibowitz
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