

IN THE MATTER OF \* BEFORE THE MARYLAND  
STEVEN W. JOHNSON, D.D.S. \* STATE BOARD OF  
Respondent \* DENTAL EXAMINERS  
License Number: 8716 \* Case Number: 2006-203

\* \* \* \* \*

**ORDER FOR SUMMARY SUSPENSION  
OF LICENSE TO PRACTICE DENTISTRY**

Based on information received by the Maryland State Board of Dental Examiners (the "Board"), concerning the dental practice of STEVEN W. JOHNSON, D.D.S. ("Respondent"), license number 8716, the Board has reasons as set forth below to find that the public health, safety and welfare imperatively requires emergency action under Md. State Gov't ("S.G") Code Ann. § 10-226(c)(2) (2004) and pursuant to the Maryland Dentistry Act (the "Act"), Md. Health Occ. ("H.O.") Code Ann. §§ 4-101 *et seq.* (2000 & Supp. 2004). The pertinent provisions of H.O. § 4-315(a), and those under which this Order is based, provide:

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

- (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
- (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; and
- (28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions.

The applicable section of S.G. § 10-226(c)(2) provides:

(c) *Revocation of [sic] suspension.* –

- (2) A unit may order summarily the suspension of a license if the unit:
  - (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
  - (ii) promptly gives the licensee:
    1. written notice of the suspension, the finding and the reasons that support the finding; and
    2. an opportunity to be heard.

### INTRODUCTION

The Centers for Disease Control (“CDC”) is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one’s hands prior to and after treating a patient, and also sets forth more involved standards for infection control. Under the Act, all dentists are required to comply with the CDC guidelines which incorporate by reference Occupational Safety and Health Administration’s (“OSHA”) final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

Based on a complaint, the Board visited and investigated the dental office where the Respondent works on a commission basis. The investigation, which is on-going, involved two visits to the office, observation of patient care, interviews with the Respondent, his dental assistant, the owner of the practice, the manager of the practice, dental staff and others, and obtaining documentation.

At the time of the office visits, no emergencies were occurring. The investigation revealed that despite the CDC guidelines, the Respondent, *inter alia*, re-uses disposable, single-use instruments and dental armamentarium, uses contaminated instruments for patient care, fails to ensure that the autoclave is spore-tested, fails to properly disinfect surfaces, and fails to use appropriate personal protective equipment. The Respondent's actions allow for the potential transmission of the HIV virus, hepatitis B and C, tuberculosis and other similar bloodborne pathogens. Instead of reducing the likelihood of infection, the Respondent's actions may result in increasing exponentially the chance of infecting his patients and others. The inspection revealed numerous other CDC violations as well.

Because the Respondent fails to take proper precautions for disease control, and otherwise practices dentistry in an incompetent and unprofessional manner, as described more fully below, the Respondent presents an immediate danger to his patients and others. As a result, allowing the Respondent to continue to practice dentistry on patients in Maryland poses a grave risk of imminent danger to the public health, safety, and welfare of the citizens of the State of Maryland.

### **INVESTIGATIVE FINDINGS**

Based upon the investigative information obtained by, received by, made known to, and available to the Board and the Office of the Attorney General, including the facts and details described below, the Board has reason to believe that the following facts are true:

1. At all times relevant hereto, the Respondent was and is a dentist licensed to practice dentistry in the State of Maryland.

2. The Respondent practices dentistry on a commission basis at North Point Dental. North Point Dental is owned by Edward Silverman, D.D.S. and the practice is operated and managed by Susan Himmel, R.D.H.

3. On or about March 8, 2006, the Board received a complaint alleging facts which, if true, would be violations of CDC guidelines. The Board referred the complaint to its investigative unit.

Office Visit, April 13, 2006

4. On or about April 13, 2006, Board investigators presented to North Point Dental. On this date neither Dr. Silverman nor Ms. Himmel were present in the office. The Respondent and his assistant, Kim Scurti, were present.

5. The investigators inspected each operatory in the office, including the operatory where the Respondent was treating patients. Each operatory had dental instruments, both disposable and re-usable, strewn about in drawers, un-bagged. These instruments were not verifiably sterile. The Respondent used these instruments during patient care and admitted that he did not know if the instruments were indeed sterile. The Respondent and Ms. Scurti advised that the instruments are never bagged for sterilization or storage after sterilization.

6. The Respondent and Ms. Scurti further advised that Dr. Silverman is only present in the office on Mondays and that Ms. Himmel operates and manages the dental office. They advised that Ms. Himmel provides the operatories, instruments, dental materials, and all supplies for each practitioner working in the office. Ms. Himmel is also responsible for ensuring proper functioning of the autoclave, removal of bio-hazardous waste, and all other administrative functions of the office. They further advised that Ms. Himmel:

- a. Directs all dentists and assistants to re-use disposable, single-use items including: prophy angles, matrix bands, suction tips, etch & bond and wells. Ms. Himmel has been observed taking disposed items from the trash for re-use.
- b. Directs all dentists and assistants to dilute Lysol cleaner used for disinfecting contaminated surfaces. The Lysol is diluted with approximately 90% water.
- c. Refuses to purchase adequate quantities of sterilization bags to use for autoclaving instruments. Ms. Himmel has told staff that the bags are expensive and that they should be used only for sterilizing gauze pads to be used for extractions. She directs the staff to place instruments directly into the autoclave without bagging. The instruments are run through the autoclave cycle without the use of a chemical indicator strip to evidence that the autoclave reached the necessary temperature to ensure sterility.<sup>1</sup>
- d. Refuses to purchase adequate quantities of personal protective apparel.
- e. Fails to spore test the autoclave to ensure sterilization of instruments.

7. The Respondent admitted that he practiced dentistry under those directives. He admitted that he could not confirm that the instruments he used were sterile. He admitted to re-using single use disposable instruments. He admitted that his operatory was disinfected with diluted Lysol. The Respondent and Ms. Scurti also failed to wear appropriate protective equipment during patient care observed that day and during room turn-over and instrument scrubbing. The Respondent advised that sterile gloves were not available and therefore not used for surgical procedures.

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<sup>1</sup> The investigators did not observe any sterilizer bags in the operatories or in the sterilization area on the first visit to the office.

8. When asked to provide evidence of spore testing of the autoclave, the Respondent advised that it had been well over a year since the autoclave was spore tested.

9. The investigators also observed blood-stained waste in regular trash bags in the public dumpster. Ms. Scurti and Dr. Johnson advised that they were told not to use the bio-hazardous waste bags too often because of the expense. They admitted to placing contaminated items in the regular trash.

10. The investigators also observed food products and dental materials contained in the same refrigerators.

### **INVESTIGATIVE CONCLUSIONS**

Based on the foregoing investigative findings, the Board concludes that the public health, safety, and welfare imperatively requires emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2004).

### **ORDER**

Based on the foregoing Investigative Findings and Conclusions, it is, by a quorum of the State Board of Dental Examiners, pursuant to the authority vested in the Board by Md. Health Occ. Code Ann. § 4-315(a) and Md. State Gov't Code Ann. § 10-226(c)(2), hereby:

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

**ORDERED** that, on presentation of this Order, the Respondent shall surrender to the Board Investigator the following items:

- 1) his original Maryland license number 8716;
- 2) the renewal card for his license to practice dentistry from the State Board of Dental Examiners;
- 3) DEA Certification of Registration number BJ6672097;

- 4) Maryland Controlled Dangerous Substances Registration Certificate Number D47677;
- 5) all controlled dangerous substances in his possession or practice;
- 6) all Medical Assistance prescription forms in his possession or practice; and
- 7) any prescription pads on which his name and DEA number are imprinted; and it is further

**ORDERED** that a Show Cause Hearing date has been reserved for **Wednesday, May 17, 2006 at 11:00 a.m.** before the Board at the Board's offices, Spring Grove Hospital Center, 55 Wade Avenue, Benjamin Rush Building, Catonsville, Maryland 21228, for the Respondent to have the opportunity to show cause as to why his license should not continue to be suspended, should the Respondent seek the hearing; and it is further

**ORDERED** that, if the Respondent intends to appear at the Show Cause Hearing on May 17, 2006, he must notify the Board, in writing, of his intent to appear and be heard. The Respondent's written intent to appear must be received in the Board's offices no later than Monday, May 15, 2006; and it is further

**ORDERED** that, if the Respondent's license remains suspended following the Show Cause Hearing, the Respondent can request an evidentiary hearing. The Respondent must request the hearing within thirty (30) days of the notice to continue the suspension. The evidentiary hearing will be held either at the Board or at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031, within forty-five (45) days of the Respondent's request for such a hearing; and it is further

**ORDERED** that if a request for an evidentiary hearing is not received in the Board's offices within thirty (30) days of the notice to the Respondent of the intent to continue the suspension, the Respondent waives all rights now and in the future to any

hearing with respect to this Order, or to any proceedings that would contest the validity of the findings of this Order for Summary Suspension, and it is further

**ORDERED** that this Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2004).

27 April 2006  
Date

Eric A. Katkow D.D.S.  
Eric A. Katkow, D.D.S.  
President  
Board of Dental Examiners