IN THE MATTER OF	*	**BEFORE THE MARYLAND**
DENISE A. NADEAU, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 12166	*	**Case Number: 2008-029**

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

INTERIM CONSENT ORDER

On or about November 7, 2007, the Maryland Board of Dental Examiners (the "Board") charged Denise A. Nadeau, D.D.S. (the "Respondent), D.O.B. 10/4/59, License Number 12166, under the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann. § 4-101 *et seq.* (2005 & Supp. 2007) (the "Act") for violations of H.O. § 4-315(a). The pertinent provisions of H.O. § 4-315(a), and those under which these charges were brought, are as follows:

> (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:
>
> (7) Has had a license to practice dentistry revoked or suspended in any other state;
>
> (19) Is disciplined by a licensing or disciplinary authority of any other state or country or convicted or disciplined by a court of any state or country for an act that would be grounds for disciplinary action under the Board's disciplinary statues; and

The applicable grounds for disciplinary action for a violation of H.O. § 4-315(a)(19) are:

H.O. § 4-315(a)(2), (6), (16), and (28):

> (2) Fraudulently or deceptively uses a license;
>
> (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.

As a result of negotiations between the Respondent, Kimberly S. Cammarata, Assistant Attorney General, and the Board, the parties agreed to enter into this Consent Order, consisting of Findings of Fact and Order, with the terms and conditions set forth below.

FINDINGS OF FACT

1. The Respondent is licensed to practice dentistry in the State of Maryland, initially receiving her license on July 25, 1998. The Respondent's license is currently inactive in this State. The Respondent is also licensed in Maine.

2. On or about August 5, 2007, the Board received information indicating that the Respondent had had disciplinary action taken against her license in Maine. The Board elected to investigate the matter.

3. On or about March 16, 2007, the Maine Board of Dental Examiners ("Maine Board") issued an Order Summarily Suspending the Respondent's license to practice dentistry in the State of Maine finding that the Respondent's continued practice of

dentistry posed an immediate threat to the health and safety of the public. (A copy of the Notice of Hearing is attached hereto and incorporated herein as Exhibit A.)

4. The Respondent was provided an opportunity for a full evidentiary hearing which occurred on May 18, June 22 and 23, 2007 before the Maine Board. On or about July 13, 2007, following the full administrative hearing, the Maine Board issued a Final Decision suspending the Respondent's license and placing the Respondent on probation with conditions. (A copy of the Order is attached hereto and incorporated herein as Exhibit B.)

5. In the July 13, 2007 Order, the Maine Board found the following facts:

a. The Respondent wrote a prescription for Vicodin and Augmentin to an employee and had the employee pick up the medications. The Respondent then took the medications herself.

b. The Respondent performed an extraction in an incompetent manner in that she failed properly document or provide a treatment plan for the extraction of two teeth of a patient. The Respondent then anesthetized the area around tooth # 18 but attempted to extract # 31 which had not been anesthetized. The Respondent took over 4 hours to extract teeth ## 18 and 31 and failed to provide post-operative instructions or care. The patient later presented to the emergency room with an infection. The Respondent also failed to record the anesthetic used and amounts used. The Respondent was described by her staff as acting erratically during the hours she attempted the extractions.

c. The Respondent failed to have infection control protocols in the office; failed to provide staff training in infection control; failed to provide Hepatitis vaccinations for staff; and failed to spore test the office autoclave.

d. The Respondent performed incompetent root canal therapy on several patients.

e. The Respondent failed to take and consider important medical history when treating patients.

f. The Respondent and another staff member physically pushed another employee to the ground, pulled up her shirt and exposed her breasts. This incident was part of an unprofessional office atmosphere wherein tequila shots were taken were licked off the bare breasts of one employee by another. The Respondent also permitted the word "erection" to be written on an office bulletin board and allowed her office manager to sell sex aids through the office. The Respondent also displayed to office staff a photograph of herself naked but for a teddy bear being held in front of her.

6. The Respondent's conduct violated the statutes, rules and regulations governing dentists in Maine.

7. The Respondent's license was suspended in Maine for a minimum of six months, effective March 16, 2007 and she was placed on probation for a period of five years. The reinstatement of the Respondent' license was conditioned upon several factors. The Respondent was required to, *inter alia,*:

a. Undergo a psychological or psychiatric evaluation on or before September 17, 2007 and the Board would consider the results of the examination;

b. Successfully complete an endodontics course prior to resuming endodontic practice;

c. Successfully complete courses in infection control, boundaries, and risk management (including treatment planning, diagnosis, documentation and record keeping);

d. Report staff members to the Board on a quarterly basis; and

e. Pay a fine and costs of the proceedings.

8. On or about November 9, 2007, the Respondent's license was reinstated in Maine subject to probationary conditions. Under the terms of the Order dated November 9, 2007, the Respondent is required to work under the direct supervision of a Board-approved supervisor who is required to file quarterly reports with the Board. She

was placed on probation for a period of five (5) years, through March 16, 2012 with the following conditions:

a. Attend and complete a Board-approved course in OSHA/CDC on or before July 13, 2008;

b. Attend and complete a Board-approved course which includes identification, prevention, and education regarding sexual misconduct, harassment and boundaries in the workplace;

c. Attend and complete a Board-approved course in risk management, including treatment planning, diagnosis, documentation and record keeping;

d. File quarterly reports with the Board listing the names and addresses of current staff; and

e. Fine and costs.

(A copy of the Order is attached hereto and incorporated herein as Exhibit C.)

9. The Respondent filed a Notice of Appeal in the State of Maine, Kennebec, Superior Court under Docket Number: AP 07-55. The appeal is pending.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board the Board finds that the Respondent has violated the Maryland Dentistry Act, H. O. § 4-315(a)(7) and (19):

(7) Has had a license to practice dentistry revoked or suspended in any other state; and

(19) Is disciplined by a licensing or disciplinary authority of any other state or country or convicted or disciplined by a court of any state or country for an act that would be grounds for disciplinary action under the Board's disciplinary statues.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is by the Maryland State Board of Dental Examiners hereby:

ORDERED that charges in this matter shall be **STAYED** and the pre-hearing conference and hearing dates postponed pending a final determination from Maine regarding the Respondent's Appeal of the Board's Order or for a period of One (1) Year, which ever date shall occur first; and it is further

ORDERED that the Respondent **SHALL BE PROHIBITED** from practicing dentistry in the State of Maryland pending a final resolution of this matter in the State of Maryland; and it is further

ORDERED that the Respondent shall forward a copy of any and all pleadings, filings, or orders, formal or informal, in the Maine action with the Maryland Board within ten (10) days of the issuance of the filing, pleading, or order; and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, and any of its agents or employees in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Interim Consent Order, and it is further

ORDERED that any violation of any of the terms of this Interim Consent Order shall constitute unprofessional conduct in addition to any other applicable grounds under the Act; and it is further

ORDERED that if the Board has probable cause to believe that the Respondent has violated any of the terms or conditions of this Interim Consent Order, the Board, after notice and an opportunity for a Show Cause Hearing before the Board, and upon a

determination of a violation, may impose any other disciplinary sanction it deems appropriate under H.O. § 4-315, said violation to be proven by a preponderance of the evidence and said failure to be deemed a violation of this Order; and it is further

ORDERED that this Interim Consent Order is a public document pursuant to Md. State Gov't Code Ann § 10-611 *et seq.* (2004 & Supp. 2007) and it will be disclosed to any national reporting data bank or other entity that the Board is mandated or otherwise obligated to report to.

IT IS SO ORDERED this 7 day of May, 2008.

5/7/08
Date

David A. Williams, D.D.S.
President
Maryland State Board of Dental Examiners

CONSENT

I, **Denise Nadeau, D.D.S.**, License No. 12166, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with counsel and I have voluntarily sought advice and counsel but have knowingly elected to proceed without an attorney before signing this document.

2. I voluntarily enter into and consent to the terms and conditions of this Interim Consent Order. I waive any right to appeal this Order as set forth in § 4-318 of the Act and Md. State Gov't. Code Ann. §§ 10-201 *et seq.* (2004 & Supp. 2007).

3. In signing this Order and agreeing to its terms, I acknowledge that I am not waiving my right to a hearing on the Charges that led to the issuance of this Order.

4. I acknowledge that by failing to abide by the conditions set forth in this Interim Consent Order and following proper procedures, I may suffer disciplinary action, which may include revocation of my license to practice dentistry in the State of Maryland.

5. I sign this Interim Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Interim Consent Order.

3/17/08
Date

Denise Nadeau, D.D.S.

NOTARY

STATE OF Florida

CITY/COUNTY OF Hillsborough

I HEREBY CERTIFY THAT on this 17th day of March, 2008, before me, a Notary Public for the State of Maryland and the City/County aforesaid, personally appeared Denise Nadeau, D.D.S., and made oath in due form of law that the foregoing Interim Consent Order was her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

SHEILA A. KOSTARES
Notary Public - State of Florida
My Commission Expires May 21, 2011
Commission # DD 677070
Bonded Through National Notary Assn.

Notary Public

My Commission Expires: 5/21/2011

STATE OF MAINE
BOARD OF DENTAL EXAMINERS
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

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7002 3150 0003 4306 7793
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May 2, 2007

Mark V. Franco, Esquire
Thompson & Bowie, LLP
P.O. Box 4630
Portland, ME 04112-4630

RE: **NOTICE OF HEARING**

Dear Mr. Franco:

As you know, on March 16, 2007, the Maine Board of Dental Examiners voted to suspend Dr. Nadeau's Maine dental license effective immediately pursuant to 5 M.R.S.A. § 10004 (3) based upon the immediate jeopardy that her continued practice of dentistry posed to the health and safety of the public.

This is to inform you that the Maine Board of Dental Examiners ("the Board") will conduct an adjudicatory hearing under the authority of 32 M.R.S.A. § 1077 and 10 M.R.S.A. § 8003 (5) to determine whether grounds exist for the Board to take disciplinary action against Dr. Nadeau's Maine dental license. The hearing is scheduled for May 18, 2007, at 9:00 a.m. at the Board office located at 161 Capitol Street, Augusta, Maine.

At the hearing, the Board will determine whether there is sufficient evidence to find that Dr. Nadeau committed the following alleged violations:

1. 32 M.R.S.A. § 1077(2)(E) Incompetence in the practice of dentistry by:

   a. Engaging in conduct that evidences a lack of knowledge or ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or

   b. Engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice of dentistry.

2. 32 M.R.S.A. § 1077(2)(F) Unprofessional conduct by violating a standard of professional behavior that has been established in the practice of dentistry.

PHONE: (207) 287-3333
FAX: (207) 287-8140
WEBSITE ADDRESS: v
E-MAIL ADDRESS: anita.

3. 32 M.R.S.A. § 1077(2)(H) A violation of this chapter or a rule adopted by the Board by:

   a. Violating Board Rule, Chapter 8, Section B, Sexual Misconduct by by engaging in an unwanted or offensive act of a sexual nature, which is neither diagnostic nor therapeutic, committed with respect to either a patient or colleague.

   b. Violating Board Rule, Chapter 8, Section E by using controlled substances or prescription drugs in any way other than for dental therapeutic purposes.

   c. Violating Board Rule, Chapter 8, Section F by inappropriately prescribing or administering drugs.

   d. Violating Board Rule, Chapter 8, Section K(7) by failing to utilize current CDC guidelines for infection control in dentistry.

The evidence supporting the foregoing alleged violations includes:

Complaint No. 06-20

1. Failure to obtain informed consent to patients prior to performing dental procedures, including root canal therapy and crowns and fillings (patients KV and DV);

2. Writing prescriptions for Vicodin, a narcotic drug, to employee TH, and then taking and using the Vicodin to treat herself for non-dental related health issues;

3. Unprofessional Conduct, including:

   a. Wearing a belly dancing costume in the dental office;

   b. Refusing to treat a patient who was five minutes late and who had driven from Jackman, Maine;

   c. Squirting a male patient in the crotch with a water syringe and stating, "I guess you're glad to see me;"

   d. Erratic and/or irresponsible behavior such as habitual tardiness and leaving work.

Complaint No. 07-126

1. Sending an employee to obtain alcohol for a party at the dental office;

2. Engaging in inappropriate sexual contact and/or behavior with or in the presence of employees;

3. Making inappropriate sexual comments and gestures towards employees and patients;

4. Using a pulp tester to punish uncooperative or complaining patients, instead of for legitimate diagnostic or therapeutic purposes;

5. Failure to offer or provide referrals for employees to obtain Hepatitis B vaccine;

6. Failure to conduct spore testing or to ensure that spore testing was being conducted on the office autoclave to ensure that it was, in fact, sterilizing dental equipment;

7. Failing to provide patients who have undergone difficult extractions with instructions for emergency follow-up care;

8. Leaving patient TA in a dental operatory for hours;

9. Repeatedly injecting patient TA with local anesthesia, and then failing to commence treatment within a reasonable period of time;

10. Injecting patient TA with local anesthesia, and then attempting to extract a tooth on the opposite side of the patient's mouth that had not been anesthetized, causing patient TA pain;

11. Injecting patient TA with 13 to 14 carpules of local anesthetic;

12. Failing to provide patient TA with appropriate information regarding follow-up care in the event of emergency.

Hearing will be in accordance with applicable provisions of the Maine Administrative Procedure Act, 5 M.R.S.A. §§ 9051 et seq. You may present evidence, call witnesses and present written or oral testimony and argument to the Board. Applications for intervention pursuant to 5 M.R.S.A. § 9054 will be accepted until commencement of hearing.

Pursuant to 10 M.R.S.A. § 8003-D, if there is a finding of violation, the Board may assess actual expenses of investigation and hearing in addition to other penalties provided by law. Such expenses include, but are not limited to, travel expenses and the proportionate part of the salaries and other expenses of investigators or inspectors, hourly costs of hearing officers, costs associated with record retrieval and the costs of transcribing or reproducing the administrative record.

Failure to appear at hearing may result in a disposition by default, and information obtained during the hearing may be used in subsequent legal proceedings. If you have any questions concerning the conduct of the hearing, please contact me at (207) 287-3333.

Please contact the Board office should you have any questions.

DATED: May 2, 2007

Teneale E Johnson

TENEALE JOHNSON
Board Assistant
Board of Dental Examiners
143 State House Station
Augusta, ME 04333

Cc: Dennis Smith, Assistant Attorney General
James E. Smith, Esq., Presiding Officer

MAINE BOARD OF DENTAL EXAMINERS

IN RE: Denise Nadeau, D.D.S.) DECISION-Disciplinary Action
Complaint Nos. 06-20; 07-10, 07-126)

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 1077 *et seq.* and 10 M.R.S.A. Sec. 8003, *et seq.*, the Maine Board of Dental Examiners (Board) met in public session on May 18, June 22 and 23, 2007 at the offices of the Board in Augusta, Maine in accordance with the provisions of 5 M.R.S.A. Sec. 9051 *et seq.* The purpose of the meeting was to conduct an adjudicatory hearing to determine whether grounds exist to support the allegations contained in the Notice of Hearing that Denise Nadeau, D.D.S. violated certain provisions of the Maine Dental Practice Act. A quorum of the Board was in attendance at all stages of the proceedings. Participating and voting Board members were Acting President Jerrold H. Cohen, D.M.D., Philip W. Higgins, D.M.D, Thomas Palmer (public member), William Buxton, L.D., Susanne J. Lavallee, R.D.H., and Kristine Blaisdell, R.D.H. Denise Theriault, D.M.D., served as the complaint officer and did not participate as a Board member in this proceeding. Dennis Smith, Assistant Attorney General, presented the State's case. Denise Nadeau was present and represented by legal counsel Mark Franco, Esq. James E. Smith, Esq., served as Presiding Officer. The exhibits consisted of the Board's statutes and Rules and State's 1-47, 54 and Respondent's 1-50.

Following preliminary questioning of the Board by the Presiding Officer relating to possible conflicts of interest and the parties' opening statements, admission of exhibits, testimony including observing the witnesses' demeanor, and closing arguments, the Board deliberated and made the following findings of fact by a preponderance of the credible evidence and conclusions of law regarding the allegations in the Notice of Hearing.

EXHIBIT B

II. FINDINGS OF FACT

A. Denise Nadeau, D.D.S. and Community Dental Center (CDC)

Denise A. Nadeau began her dental career as a dental assistant for approximately 10 years. She has been a licensed dentist since 1997 when she graduated from the University of Maryland and commenced to practice her profession in that state in 1998. In Maryland, Dr. Nadeau worked for several dental offices part-time including 2 or 3 in Columbia but couldn't recall the name of the practices or why she was terminated from one. During this time, the licensee generally did not perform root canals and referred those procedures to an endodontist.

Dr. Nadeau and her physician husband, a native of Iraq, moved to Maine in 2003 due to the fact that he had received a fellowship and was training to specialize in geriatrics. The Respondent became a licensed Maine dentist in July of that year and her current license expires on May 18, 2007. Shortly after her licensure, Dr. Nadeau was hired by the CDC in Waterville, Maine to practice general dentistry and as the dentist of record. CDC restricted its clientele to low or no income families and Dr. Nadeau earned forgiveness of $50,000 in student loans for committing to at least 2 years of practice at that facility.

Dr. Nadeau shared the CDC practice with a part-time dentist who subsequently left the practice. She was assisted in the practice by at least three individuals who were either dental assistants or hygenists. These individuals apparently engaged in inappropriate gossip which involved Dr. Nadeau. Dr. Nadeau expressed her concerns to the executive director of CDC who terminated the employment of 2 of the employees and reprimanded the third. Since Dr. Nadeau left the CDC practice in December 2005, no other dental personnel have been terminated.

B. Tamara Holmes

In March 2004, Dr. Nadeau replaced one of the above individuals with Tamara Holmes who was employed in a local bagel shop and had no prior experience working in a dental practice. In May 2005, Dr. Nadeau performed a root canal on one of Ms. Holmes's teeth and prescribed for her Vicodin, a Schedule III controlled substance. Several months later on a Saturday, Dr. Nadeau was subjected to a bout of trigeminal neuralgia which occurred while at work. She could not reach her

physician, and rather than contacting her husband for a referral or going to a nearby emergency room, she prescribed Vicodin and Augmentin for Tamara Holmes at a nearby pharmacy. Ms. Holmes picked up the pills and returned to CDC where she gave them to Dr. Nadeau as requested. Dr. Nadeau did not record the prescription in Tamara Holmes's dental record or elsewhere.

Dr. Nadeau admitted at this hearing that she knew her actions were wrong and that she committed unprofessional conduct when she self-prescribed for these drugs. Dr. Nadeau was subsequently suspended from practice for a period of 2 weeks by the CDC Board as a result of this episode. She was also evaluated for substance abuse which was not diagnosed and offered to participate in random drug testing, which offer was declined. Dr. Nadeau began to make plans by the fall of 2005 to establish her own dental clinic. She gave her notice to CDC but left the practice on or about February 13, 2006, a few weeks before her stated notice. However, her patients were provided with emergency services by another provider. The new practice, Emergency Dental Services (EDS), opened its doors in Waterville, Maine to patients in April 2006. 80% of Dr. Nadeau's patients earned low incomes.

C. August 18, 2006 Office Party and the Sexual Environment at Emergency Dental Services

On the above date, a Friday, the staff and Dr. Nadeau decided to have an after hours office party. Accordingly, in the mid to late afternoon, Dr. Nadeau requested that dental assistant Joyce Stratton buy some food and liquor, including flavored rum and tequila. Joyce was accompanied on the shopping errand by a male friend, Robert Curtis. On return to the office, Stratton set up the liquor and food in a separate room. Dr. Nadeau, Stacey Hachey (office manager-bookkeeper), Matthew Allen (dental assistant), Joyce Stratton and Robert Curtis were in attendance. At least one shot of tequila was taken by each and beer and wine coolers were also later introduced to the party by Curtis. At some point, Dr. Nadeau and Matthew Allen[1] pushed Joyce Stratton to the floor, pulled up her blouse, and exposed her breasts. Ms. Stratton resisted these assaults but later joined the other individuals who were in another room.

Subsequently, a similar assault took place which was witnessed by four individuals, including Ms. Hachey. This time, salt and tequila were put on Ms. Stratton's bare breast and licked

[1] At this hearing, Matthew Allen testified that at first, he had denied that Dr. Nadeau participated in the Stratton incidents because he was concerned that the staff would lose their jobs if Dr. Nadeau lost her license. Additionally, Dr. Nadeau had requested him not to mention the fact that she was in the room during the body shots.

off by Matthew Allen. Dr. Nadeau later denied that the first assault took place and was the only individual who denied witnessing the latter episode since she testified that she was busy in another room talking on the phone with her son who was having some family problems. Her denial of the event was found incredible by the Board. The party ended after approximately 1 ½ to 2 hours. Matthew Allen then became sick in the bathroom and was driven home by Dr. Nadeau. Robert Curtis and Joyce Stratton were too inebriated to drive for a period of time.

On another occasion, during office hours, Dr. Nadeau displayed to 2 employees a nude photo of herself except for a teddy bear which she held in front of her. She admitted that she allowed sexual aids to be sold over the telephone by her office manager for a period of time and permitted the word "erection" to remain on the office blackboard when that term had no professional relationship with any training or dental practice. Dr. Nadeau also allowed off-color e-mails to be sent to her in her office setting and forwarded same to others.

D. Patient T.A.

T.A., 26 years old, was a MaineCare female patient who first received treatment at the clinic on March 8, 2007. She had serious problems with two particular teeth, numbered 31 and 18, on opposite sides of her mouth and wanted them extracted as they were causing her pain. The licensee did not discuss with T.A. whether either of T.A.'s teeth was restorable and neither did she offer to refer the patient to an oral surgeon. Moreover, there was no written diagnosis or treatment plan in T.A.'s record which omission was admitted by Dr. Nadeau to be a violation of the standard of care. Dr. Nadeau informed her that she could only pull tooth #31 at that time which had a hole in it. Novocain was administered several times in the intervening hours but numbness of the area was difficult to achieve. After a while, Dr. Nadeau reappeared and either attempted to pull the tooth or test for numbness with an instrument denominated as a back angle elevator by dental assistant Matt Allen and a periodontal elevator by Dr. Nadeau.[2] At any rate, the Respondent applied pressure to the wrong tooth, #18, which had not been anesthetized. Dr. Nadeau's mistake caused T.A. extreme pain. Dr. Nadeau recognized her mistake immediately ("Oh my God, it's the wrong tooth") and said that she would pull that tooth as well.

[2] Mr. Allen was hired by Dr. Nadeau on March 10, 2006. He was a massage therapist who was selling credit card machines at the time and had no prior training in the field of dentistry.

The extraction of the first tooth took approximately 1 ½ hours. The second tooth an additional 2 ½ hours. Once again, numbness was difficult to achieve, and T.A. screamed at one point as the extraction was taking place. An additional dose of anesthetic apparently resolved the problem, but the patient was left in the operatory for almost 5 hours mostly in pain which Dr. Nadeau admitted was too long and apologized to T.A. However, the licensee did not provide T.A. with an after hours emergency phone number and neither did she receive post-care instructions or a follow-up phone call or appointment.

Following the two extractions, T.A. testified that she was nauseous, had a pounding headache, and felt as though her "face was going to explode" when she left the clinic. She then drove to a nearby friend's house and spent the night there. Several days later, she remained in significant pain and was treated at the emergency room with drugs for a "dental infection."

In addition to attempting to preliminarily pull or test tooth #18 for numbness without numbing the area first, the licensee also neglected to note in T.A.'s record that she had made that mistake. Neither did she note when the different carpules of anesthetic were given or when the treatment ended. Moreover, Dr. Nadeau, in her written response to the Board, stated that T.A. said "I feel that" when she "touched" the gingiva of tooth #18. The patient, however, rendered a more accurate rendition of her comments by testifying that her reaction was "I yelled out in pain."

Other staff present at EDS that day similarly described the extractions regarding T.A. For example, Kim MacDonald-Disanto hired with no dental training, assisted in the operatory as a dental assistant from August 6, 2006 until March 7, 2007. She periodically checked on T.A. in the operatory but found the overall situation regarding patient safety in March 2007 to be "terrifying" and observed that Dr. Nadeau was acting erratically. The licensee was under great stress occasioned by her and her husband's attempts to successfully extricate his family out of Iraq and to the United States. The complaints filed by the Board added further stress as did the dental office atmosphere which had become increasingly poisoned following the August 18, 2006 office party.

E. Failure to Utilize Current Center for Disease Control Guideline's for Infection Control

Board Rule Chapter 8, §2 (K) (7) provides that it is unprofessional conduct to fail to utilize current Center for Disease Control guidelines for infection control in dentistry in effect at the time of treatment. During her dental practice and before her license was suspended by the Board on

March 16, 2007, Dr. Nadeau was only "a bit familiar" with Center for Disease Control requirements and did not adequately train her staff or have written protocols for infection control despite having contact with more than 3,000 low-income patients from April 2006 until March 2007. For example, although she instructed her staff to be vaccinated for Hepatitis B, she never followed through to ensure that they had received this protection. In fact, Dr. Nadeau implied that it was the staff's responsibility to ensure that they had received the shots, even though she admitted to overall responsibility for the safety of staff and patients.

Dr. Nadeau testified to the Board that if she knew that a patient was Hepatitis B positive, Matthew Allen would assist her in treatment. This was because Matthew had allegedly informed her that he had been given the necessary vaccinations while in the army, but Dr. Nadeau never requested proof of this assertion. At this hearing, Matthew couldn't recall if he had specifically received the Hepatitis B vaccination and, remarkably, it never occurred to Dr. Nadeau that she may be exposing other staff members to the virus while treating an individual who unknowingly had the virus.

It is common knowledge in the medical and dental field that Hepatitis B and other blood borne pathogens are well known occupational risks. The pathogens may be transmitted from patient to dentist, dentist to patient, dentist to staff, staff to non-patients, etc. The Center for Disease Control recommended that "Because of the high risk of Hepatitis B among health care personnel, dental health care personnel who perform tasks that might involve contact with blood, blood-contaminated body substances, other bodily fluids or sharps should be vaccinated." As the dentist in charge, it was Dr. Nadeau's responsibility to ensure that the staff was vaccinated, particularly since most of the employee at EDS did not have prior dental or health field related training.

Along the same lines, spore testing is a sterilization monitoring process highly recommended by the Center for Disease Control whereby a treated test strip is placed in the autoclave with the dental instruments that are to be sterilized. Following the sterilization process, the strip is sent to a lab and the results returned regarding whether microorganisms remain. Dr. Nadeau did not ensure that spore testing was performed until March 2007 although she ordered Matthew Allen to perform the test beginning in February 2007.[3]

[3] The Board was concerned with Dr. Nadeau's repeated failure to ensure that standard operating procedures at her office were carried out in a timely manner. For example, the failure to make sure that her staff was vaccinated against Hepatitis B; the failure to timely make sure that spore testing was performed when she recognized that it was not being done; the failure to ensure that patients were being contacted within a reasonable time after tooth extractions or similar

F. Dr. Voss and Dr. Siegel

The Board, following its preliminary investigation of the above cited incidents, decided effective March 16, 2007 to suspend Dr. Nadeau's license to practice dentistry. Subsequently, Dr. Nadeau was examined by Carlyle Voss, M.D. with a specialty in psychiatry. Dr. Voss examined Dr. Nadeau for three hours on May 11, 2007. During that time, they briefly discussed the office party where she stated that Robert Curtis and Joyce Stratton did body shots (drinking alcohol from a belly button or elsewhere) but that she declined to participate. She further stated that after her alleged conversation with her son, she returned to the room and Robert put his head up her skirt which she stopped. She also referred to patient T.A. Contrary to T.A.'s testimony, the licensee told Dr. Voss that the patient "tolerated [the procedure] well" and that "the outcome was good." Additionally, Dr. Nadeau did not share with Dr. Voss that was habitually late to her practice and that she had prescribed the Vicodin to Tamara Holmes that she later herself ingested.

Dr. Voss concluded his 13 page report by giving his diagnoses, the most relevant of which are that there is no evidence of a psychiatric disorder or personality disorder. He rendered his opinion that Dr. Nadeau was not a threat or risk to patients in terms of her professional behavior. However, rather than interviewing other individuals or collateral sources, this professional relied solely on Dr. Nadeau's statements and accepted them at face value.

The Board then heard the testimony of Jonathan Siegel, Ph.D. Dr. Siegel is a forensic psychologist who testified that Dr. Voss's evaluation was not a forensic exam which lacked several important points of information such as psychological testing including the Minnesota Multiphasic Personality Inventory (MMPI) test. Dr. Siegel testified that the amount of contacts were less than adequate to support Dr. Voss's diagnoses. Additional contacts would be expected to include the MMPI results and interviews of family members, spouses, ex-spouses, etc. As a result of this testimony, the Board chose to address in its order the need for a more complete mental evaluation of Dr. Nadeau's ability to practice dentistry.

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procedures; the failure to timely follow through on her request to Ms. Hachey not to sell or arrange for sexual aids to be sold at the EDS practice.

G. Endodontics

Dr. Nadeau admitted that she does not like performing posterior root canals and would be more comfortable working in a dental office without doing any root canals. She estimated that she performed approximately 5-6 root canals a month and estimated her success rate in endodontics to be 80% whereas the standard rate of success is purported to be 95%. Her mistakes in this area appeared to be related to inexperience. Moreover, the root canal performed on D.V. did not appear to be competently performed and neither was it recorded in his dental record. Additionally, the root canal performed on Tamara Holmes needed to be redone. The root canal on Kim MacDonald-Disanto's mother apparently should not have been started due to the amount of time between treatments which resulted in receded gums. Finally, Dr. Nadeau also inappropriately attempted to restore several patients' teeth, including those of Dr. F.S., by performing a root canal when those efforts were contraindicated from the outset.

H. Miscellaneous concerns

It also became apparent to the Board that Dr. Nadeau's record keeping was deficient in a number of ways. Her post-treatment instruction forms did not mention "dry socket" and she did not abide by standard practice in questioning some patients regarding their medical conditions before treating them. For example, she did not make adequate inquiry of R. R., Jr. regarding his heart condition and did not take his blood pressure even though he had a history of high blood pressure. The Board also was concerned that the office staff was not privy to any training manuals which outlined their duties and responsibilities and neither did the staff receive OSHA training or have an employee designated and trained as the safety officer. There were also no established protocols at CDC for probing new patients or for x-rays. Although Dr. Nadeau expressed good intentions towards having these problems addressed, she did not since she "became swamped" at work.

The Board also was concerned by the pattern of arriving late for work in the morning and/or after lunch while at CDC. Dr. Nadeau did not seem to comprehend that when a patient while waiting for treatment informed Dr. Nadeau's staff that she "can't stay any longer," it was because Dr. Nadeau was late, not because the patient was impatient.

Dr. Nadeau stated that if she was allowed to return to practice, she would try to find trained staff and ensure the documentation of their vaccinations and educate them regarding sterilization procedures. Additionally, she would comply with the OSHA requirements and make sure that she and her staff received appropriate training in dental charting and record keeping. She would also take courses to improve her skills should she perform root canals. Dr. Nadeau further evinced her intention to establish appropriate boundaries with her staff and would not let events similar to those which took place on August 18, 2006 occur again in her practice.

I. Additional Comments

Although the findings above focus on Dr. Nadeau's shortcomings as a dentist, several witnesses appeared on her behalf and testified that she was skilled, caring, and compassionate regarding her dental practice. She also contributed to filling a serious need for available dentists in the Augusta/Waterville area and was one of the few dentists who provided emergency care to lower income patients without a long waiting period. In fact, physicians periodically extract teeth due to the lack of available dentists.

III. CONCLUSIONS OF LAW

The Notice of Hearing in this matter listed several alleged violations of Board statutes and Rules. The Board, subsequent to the close of the evidence, and applying its members' expertise, training, and knowledge, concluded by a unanimous vote of 6-0 that Dr. Nadeau violated the following Board statutes and Rules with examples of those violations noted.

1. 32 M.R.S.A. § 1077(2)(E) Incompetence in the practice of dentistry by:

a. Engaging in conduct that evidences a lack of knowledge or ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or

b. Engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice of dentistry.

Dr. Nadeau injected patient T.A. with local anesthesia, and then attempted to test or extract a tooth on the opposite side of the patient's mouth that had not been anesthetized, causing patient T.A. significant pain. The licensee then left patient TA in a dental operatory for hours. She then failed to provide patient T.A. with appropriate information regarding follow-up care in the event of emergency.

Dr. Nadeau additionally did not protect her patients, staff, or the public by ensuring that her staff was vaccinated for Hepatitis B. Moreover, she did not protect her patients by ensuring that proper sterilization techniques were being performed. In that regard, Dr. Nadeau failed to conduct spore testing or to ensure that spore testing was being conducted on the office autoclave to check that it was, in fact, sterilizing dental equipment.

Dr. Nadeau, by her own admission and combined with her treatment related to R.R. Jr., D.V., and Kim Disanto's mother, did not demonstrate competency regarding her endodontics practice. Additionally, there was a failure to maintain adequate record keeping standards and treatment plans were not shared with some patients. There was also a lack of post-op care for other patients with no instructions for emergency follow-up care or an answering machine message at the clinic informing a patient where to seek emergency care.

2. 32 M.R.S.A. § 1077(2)(F) Unprofessional conduct by violating a standard of professional behavior that has been established in the practice of dentistry.

Dr. Nadeau engaged in unwanted sexual assaults on Ms. Stratton and demonstrated other sexual inappropriate behavior in her dental practice. (See #3 a. below) Additionally, Dr. Nadeau inappropriately shared at least one photo of her with two staff members and illegally prescribed Vicodin for Tamara Holmes for the licensee's own use.

3. 32 M.R.S.A. § 1077(2)(H) A violation of this chapter or a rule adopted by the Board by:

a. Violating Board Rule, Chapter 8, Section B, Sexual Misconduct, which is defined as "an unwanted or offensive act of a sexual nature, which is neither diagnostic nor therapeutic, committed with respect to either a patient or a colleague. It may include but is not limited to:

...physical contacts of a sexual nature, such as intentional touching of a body part for any purpose other than appropriate examination and treatment, or when a patient has refused or withdrawn consent...Sexual misconduct may be established by a single act or by a series of acts. Sexual misconduct may also be established where such acts create a hostile environment of which the dental professional either is, or has reason to be, aware. In determining an appropriate sanction for a sexual misconduct violation, consideration will be given to the following factors:[4] patient harm (distress and embarrassment), severity of impropriety (very serious); culpability of the dental professional (one of two prime actors); age of patient (44) or colleague; physical/mental capacity of patient (normal) or colleague; number of times behavior occurred (twice); and nature and length of any existing, non-professional relationship (none). The above list is not intended to be exclusive."

Examples of violations of this Rule include the sexual assaults on Ms. Stratton. Also, Dr. Nadeau displayed a photo of herself nude except for a teddy bear covering most of her front to 2 employees. She admitted that she allowed sexual aids to be sold over the telephone by her office manager and permitted the word "erection" to remain on the office blackboard when that term had no professional relationship with any training or dental practice. Dr. Nadeau also allowed off-color e-mails to be sent to her in her office setting and forwarded same to others.

b. Violating Board Rule, Chapter 8, § E by using controlled substances or prescription drugs in any way other than for dental therapeutic purposes.

Dr. Nadeau consumed Vicodin for other than dental purposes that she prescribed for Tamara Holmes.

c. Violating Board Rule, Chapter 8, § F by inappropriately prescribing or administering drugs.

Dr. Nadeau inappropriately prescribed drugs to Tamara Holmes.

d. Violating Board Rule, Chapter 8, § K (7) by failing to utilize current CDC guidelines for infection control in dentistry.

[4] The comments in parentheses are those of the Board and related to Ms. Stratton.

Months passed without spore testing or vaccinations to protect against Hepatitis B.

IV. SANCTIONS

The Board, by a unanimous vote of 6-0, ordered that:

1. Dr. Denise Nadeau's license to practice dentistry is hereby suspended for a period of six months commencing March 16, 2007, for the purpose of protecting the public, as a sanction for her violations of Board statutes and Rules, and in order to determine her competency to practice dentistry. The decision whether to extend the suspension and/or to grant relicensure depends on whether Dr. Nadeau complies with the relevant terms of probation regarding the psychological or psychiatric evaluation.

2. Dr. Denise Nadeau shall be placed on probation for a period of five years. During this time, she shall:

a. successfully complete a psychological or psychiatric evaluation with a provider pre-approved by the Board before September 16, 2007. The evaluation shall include an MMPI and address whether Dr. Nadeau is competent to practice general dentistry and whether as a dentist her practice would pose a threat of harm to the public. The Board will then re-evaluate this matter at a scheduled hearing and decide whether the evaluation reveals positive findings and conclusions which would support her return to dental practice.

b. successfully complete a hands-on course in endodontics therapy before returning to practice any form of endodontics.

c. attend and successfully complete, by July 13, 2008, a Board pre-approved OSHA/CDC course in order to deal with the prevention and control of infectious diseases and proper sterilization procedures in the dental practice. This course shall not count towards continuing education credits.

d. shall attend and successfully complete, by July 13, 2008, a Board pre-approved course which includes identification, prevention, and education regarding sexual misconduct, harassment and boundaries in the workplace. This course shall not count towards continuing education credits.

e. shall attend and successfully complete, by October 13, 2007, a Board pre-approved

course in risk management which includes components of treatment planning, diagnosis, documentation, and record keeping.

f. shall submit quarterly reports to the Board listing the names and contact information of current staff.

g. pay the maximum fine of $1,500 for the found sexual violations. The payment of the fine shall be held in abeyance until July 13, 2008. The payment shall be by certified check or money order and made **payable to the Treasurer, State of Maine** and mailed to Teneale Johnson, Acting Executive Secretary, Board of Dental Examiners, 143 State House Station, Augusta, Maine 04333-0143.

h. Dr. Denise Nadeau shall **pay $18,447.43 for the costs** of the hearing and shall also be responsible for any additional payment for the transcription of these proceedings if requested by her. The payment of the costs shall be held in abeyance until July 13, 2008. (Hearing Officer- 6 hours and 45 mins. to review file and conduct pre-hearing conferences of counsel, etc.; 42 hours at hearing; 16 hours and 15 mins. to write Decision @ $115 per hour = $7,475; Dr. Siegel=$930; court reporter attendance for 3 days = $2,786.25; copying costs @ $.25=$841.75; staff time=$35; witness/travel fees-$500; + investigations = $4,740.64 + publishing notices of hearing $1,138.79). The certified check or money order shall be made **payable to the Maine Board of Dental Examiners** and mailed to Teneale Johnson, Acting Executive Secretary, Board of Dental Examiners, 143 State House Station, Augusta, Maine 04333-0143. The costs are consistent with past Board practices. The Board is of the opinion that those licensees who violate Board Rules and statutes as opposed to those who don't should pay the Board's hearing related costs, especially since the Board is solely funded by its licensees' licensure fees.

SO ORDERED.

Dated: July 13, 2007

Jerrold H. Cohen D.M.D

Jerrold H. Cohen, D.M.D, Acting President
Maine Board of Dental Examiners

V. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3 and 10 M.R.S.A. Sec. 8003, any party that appeals this Decision and Order must file a Petition for Review in the Maine Superior Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine Board of Dental Examiners, all parties to the agency proceedings and the Attorney General.