

APPROVED

BOARD OF DENTISTRY

MINUTES

SPECIAL CONFERENCE COMMITTEE "A" MEETING

- TIME AND PLACE:** Special Conference Committee "A" convened on November 16, 2007 at 9:07 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, VA 23233.
- APPROVAL OF MINUTES:** Ms. Pace moved to approve the minutes of the Special Conference Committee "A" meeting held on July 13, 2007. The motion was seconded and passed.
- FIRST CONFERENCE:** 9:07 a.m.
- PRESIDING:** Meera A. Gokli, D.D.S.
- MEMBERS PRESENT:** Jacqueline Pace, R.D.H.
- STAFF PRESENT:** Alan Heaberlin, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Julia Bennett, Adjudication Specialist
- OTHERS PRESENT:** William C. Garrett, Assistant Attorney General
- QUORUM:** Both members of the Committee were present.
- Ronald L. Rosenthal, D.D.S.
Case Nos. 89541 and 103641**
- Ronald L. Rosenthal, D.D.S., appeared with counsel, Mark Baron, Esq. to discuss allegations that he may have violated laws and regulations governing the practice of dentistry in that
1. From approximately 1997 to 2004, he practiced outside the scope of dentistry and/or failed to conform to acceptable standards of care when he treated Patients A-E, G, H, and J-Q for obstructive sleep apnea without first obtaining a diagnosis of that condition by a physician.
 2. He failed to obtain a follow-up polysomnography to determine the efficacy of the oral appliance with which he treated Patients F, I, and Q for obstructive sleep apnea.
 - 3a. He fraudulently obtained the consent of Patients A-C, E, G, J-O to treatment for sleep apnea. Specifically, his written consent forms state that

sleep apnea is a medical condition that must be diagnosed by a physician and that patients who have not been referred by a physician will be referred for a comprehensive physical exam prior to treatment. However, Patients A-C, E, G, J-O were not diagnosed by, or referred for a physical exam to, a physician prior to him treating them for sleep apnea.

- 3b. He failed to obtain the consent of Patients D, H, P, and Q for treatment of sleep apnea or any other condition.
4. His records for Patient R fail to include a health history.
5. He engaged in advertising that is expressly or implicitly false, deceptive, misleading, and/or contains claims of superiority. Specifically:

- a. He published or caused to be published in the Staunton News Leader on or about August 30, 2006, an advertisement entitled "Attention SLEEP APNEA Sufferers!" that states:

A local Doctor's [Dr. Rosenthal's] shocking new free report reveals the real truth about Sleep Apnea and why you don't have to wear CPAP ever again! If you've been told you do not have any other options, and are stuck with CPAP, and feeling like your lungs are being blown out, you've been misinformed! That's right, you'll never again have to worry about the noise, claustrophobia, sore nose, or the dried out mouth & throat, and repeated upper respiratory infections!! ...Don't suffer irritating, uncomfortable CPAP anymore. **YOU DON'T HAVE TO!!!**

- b. The free report referred to in the foregoing ad, entitled "The Truth About Sleep Apnea—How to find a dentist who treats Sleep Apnea Quickly, Predictably and Well", states that, the purpose of the report is "to help you get the best tolerated, most comfortable treatment for Sleep Apnea", a claim of

superior treatment that is not substantiated. The report states that although "[t]he usual recommendation is that you first have a full sleep test to figure out if you have Sleep Apnea, I [Dr. Rosenthal] personally disagree with that approach, for several reasons", including the fact that "[m]ost sleep laboratories are very backed up and cannot schedule your diagnostic test for about six months", another claim that is not substantiated. The report also states that "I prefer to treat you right away with an Oral Appliance. There is plenty of time for a sleep test later." These statements imply persons with suspected sleep apnea should be treated before they have a definitive diagnostic test, a protocol that is contrary to accepted standards of practice.

6. On January 24, 2005, he delivered an inferior lower denture to Patient Z. Between January 28, 2005 and March 28, 2005, the denture was adjusted six times. Patient Z stated that she is unable to use the lower dentures when eating.
7. He failed to document in Patient Z's dental records her name, health history, and the identity of the dentist providing the service.
8. He allowed his two dogs to run free throughout his home office while treating patients. By letter dated April 29, 2005 to the Better Business Bureau of Western Virginia, he stated that the dogs have free rein of the "whole house" and greet patients when they arrive at his practice.

On behalf of Dr. Rosenthal, Mr. Baron presented the Committee a proposed Consent Order for consideration.

On behalf of the Commonwealth, Mr. Garrett presented the Committee with an argument opposed to the proposed Consent Order.

Closed Meeting:

Ms. Pace moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision

in the matter of Ronald L. Rosenthal, D.D.S. Additionally, Ms. Pace moved that Board staff, Alan Heaberlin, and Cheri Emma-Leigh, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Dr. Gokli stated that it was the decision of the Committee to reject the proposed Consent Order.

The Committee received Dr. Rosenthal's statements and discussed the evidence in the case with him.

The Committee received statements from Michael W. Bowler, D.D.S., Commonwealth Expert Witness.

Closed Meeting:

Ms. Pace moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Ronald L. Rosenthal, D.D.S. Additionally, Ms. Pace moved that Board staff, Alan Heaberlin, and Cheri Emma-Leigh, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Mr. Heaberlin read the Findings of Fact and Conclusions of Law and Sanctions imposed as adopted by the Committee as follows:

1. Dr. Rosenthal currently holds a Virginia dental license.
2. Dr. Rosenthal violated § 54.1-2706(5), (11) and (12) of the Code, in that, from approximately 1997 to 2004, he practiced outside the scope of dentistry and/or failed to conform to acceptable standards of care when he treated Patients A-E, G, H, and J-Q for obstructive sleep apnea without first obtaining a diagnosis of that condition by a physician.
3. Dr. Rosenthal violated § 54.1-2706(5) and (11) of the Code, in that he failed to obtain a follow-up polysomnography to determine the efficacy of the oral appliance with which he treated Patients F, I, and Q for obstructive sleep apnea.
4. Dr. Rosenthal violated § 54.1-2706(4) of the Code, and 18 VAC 60-20-170(1) and (2) of the Regulations, in that, he fraudulently obtained the consent of Patients A-C, E, G, J-O to treatment for sleep apnea. Specifically, his written consent forms state that sleep apnea is a medical condition that must be diagnosed by a physician and that patients who have not been referred by a physician will be referred for a comprehensive physical exam prior to treatment. However, Patients A-C, E, G, J-O were not diagnosed by, or referred for a physical exam to, a physician prior to his treating them for sleep apnea.
5. Dr. Rosenthal violated 54.1-2706(7) of the Code, and 18 VAC 60-20-180.F(1), (2) and (4) of the Regulations, in that he engaged in advertising that is expressly or implicitly false, deceptive, misleading, and/or contains claims of superiority. Specifically:
 - a. He published or caused to be published in the Staunton News Leader on or about August 30,

2006, an advertisement entitled "Attention SLEEP APNEA Sufferers!" that states:

A local Doctor's [Dr. Rosenthal's] shocking new free report reveals the real truth about Sleep Apnea and why you don't have to wear CPAP ever again! If you've been told you do not have any other options, and are stuck with CPAP, and feeling like your lungs are being blown out, you've been misinformed! That's right, you'll never again have to worry about the noise, claustrophobia, sore nose, or the dried out mouth & throat, and repeated upper respiratory infections!! ...Don't suffer irritating, uncomfortable CPAP anymore. **YOU DON'T HAVE TO!!!**

- b. The free report referred to in the foregoing ad, entitled "The Truth About Sleep Apnea—How to find a dentist who treats Sleep Apnea Quickly, Predictably and Well", states that, the purpose of the report is "to help you get the best tolerated, most comfortable treatment for Sleep Apnea", a claim of superior treatment that is not substantiated. The report states that although "[t]he usual recommendation is that you first have a full sleep test to figure out if you have Sleep Apnea, I [Dr. Rosenthal] personally disagree with that approach, for several reasons", including the fact that "[m]ost sleep laboratories are very backed up and cannot schedule your diagnostic test for about six months", another claim that is not substantiated. The report also states that "I prefer to treat you right away with an Oral Appliance. There is plenty of time for a sleep test later." These statements imply persons with suspected sleep apnea should be treated before they have a definitive diagnostic test, a protocol that is contrary to accepted standards of practice.
6. Dr. Rosenthal violated § 54.1-2706(5) of the Code, in that he allowed his two dogs to run free throughout his home office while treating patients.

By letter dated April 29, 2005 to the Better Business Bureau of Western Virginia, Dr. Rosenthal stated that the dogs have free rein of the "whole house" and greet patients when they arrive at your practice.

The sanctions reported by Mr. Heaberlin were that Dr. Rosenthal be issued a reprimand, be assessed a monetary penalty of \$11,000.00, and be subjected to semi-annual inspections for two (2) years of ten (10) patient records for patients he is treating for Obstructive Sleep Apnea (OSA).

Ms. Pace moved that the Committee adopt the Findings of Fact and Conclusions of Law, and the sanctions as reported by Mr. Heaberlin. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Rosenthal unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Rosenthal. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this Committee shall be vacated.

**SECOND
CONFERENCE:**

1:55 p.m.

PRESIDING:

Meera A. Gokli, D.D.S.

MEMBERS PRESENT:

Jacqueline G. Pace, R.D.H.

STAFF PRESENT:

Alan Heaberlin, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Gail W. Ross, Adjudication Specialist

QUORUM:

Both members of the Committee were present.

**John M. Prince, D.D.S.
Case No. 94545**

John M. Prince, D.D.S., appeared without counsel to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that, in or about September 2003, by his own admission, he failed to wear gloves while examining Patients A and B.

The Committee received Dr. Prince's statements and discussed the evidence in the case with him.

Closed Meeting:

Ms. Pace moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of John M. Prince, D.D.S. Additionally, Ms. Pace moved that Board staff, Alan Heaberlin and Cheri Emma-Leigh, and Administrative Proceedings Division staff, Gail Ross, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Ms. Ross read the Findings of Fact and Conclusions of Law and Sanctions imposed as adopted by the Committee as follows:

1. Dr. Prince currently holds a Virginia dental license.
2. Dr. Prince violated § 54.1-2706(11) of the Code, in that, in or about September 2003, by his own admission, he failed to wear gloves while examining Patients A and B.

The sanctions reported by Ms. Ross were that Dr. Prince be issued a reprimand, be assessed a monetary penalty of \$1,000.00, and be required to complete the on-line ADA Infection Control and OSHA course for two (2) continuing education hours.

Ms. Pace moved that the Committee adopt the Findings of

Fact and Conclusions of Law, and the sanctions as reported by Ms. Ross. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Prince unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Prince. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this Committee shall be vacated.

THIRD CONFERENCE:

3:24 p.m.

PRESIDING:

Meera A. Gokli, D.D.S.

MEMBERS PRESENT:

Jacqueline G. Pace, R.D.H.

STAFF PRESENT:

Alan Heaberlin, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Cynthia E. Gaines, Adjudication Specialist

QUORUM:

Both members of the Committee were present.

**Alexander Osinovsky,
D.D.S.
Case No. 97217**

Alexander Osinovsky, D.D.S., appeared with counsel, Richard W. Boone, Sr., Esq., to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that

1. Before placing a crown on Patient A's tooth #19 on September 6, 2001, he failed to diagnose and treat an incomplete endodontic filling.
2. Entries made in Patient A's records did not include all of the required information. Specifically:
 - a. The entry made on March 15, 2001, does not include the name and amount of the anesthesia administered.
 - b. The entry made on March 22, 2001, does not indicate what percentage of xylocaine was

- c. administered and if it included epinephrine. The entry made on April 16, 2001, does not include the name and amount of anesthesia administered.
- d. The entry made on July 16, 2001, does not indicate what percentage of xylocaine was administered and if it included epinephrine.

3. He charged patient A for a crown on tooth #3, which was not seated.

The Committee received Dr. Osinovsky's statements and discussed the evidence in the case with him.

Closed Meeting:

Ms. Pace moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Alexander Osinovsky, D.D.S. Additionally, Ms. Pace moved that Board staff, Alan Heaberlin and Cheri Emma-Leigh, and Administrative Proceedings Division staff, Cynthia Gaines, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Ms. Gaines read the Findings of Fact and Conclusions of Law and Sanctions imposed as adopted by the Committee as follows:

1. Dr. Osinovsky currently holds a Virginia dental license.
2. Dr. Osinovsky violated § 54.1-2706(9) of the Code, in that, entries made in Patient A's records did not include

all of the required information. Specifically:

- a. The entry made on March 15, 2001, does not include the name and amount of the anesthesia administered.
 - b. The entry made on March 22, 2001, does not indicate what percentage of xylocaine was administered and if it included epinephrine.
 - c. The entry made on April 16, 2001, does not include the name and amount of anesthesia administered.
 - d. The entry made on July 16, 2001, does not indicate what percentage of xylocaine was administered and if it included epinephrine.
3. Dr. Osinovsky stated to the Committee that he has completed a continuing education course to learn how to properly chart dental records.

Ms. Gaines reported that no sanctions will be imposed. Ms. Pace moved to adopt the decision of the Committee. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Osinovsky unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Osinovsky. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this Committee shall be vacated.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 4:31 p.m.

Meera A. Gokli, Chair

Sandra K. Reen, Executive Director

Date

Date