COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

BEFORE THE STATE BOARD OF DENTISTRY

COMMONWEALTH OF PENNSYLVANIA,
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

v.

BLANCHE DURAND GRUBE, D.M.D.

CASE NOS. 18-46-02952 and 18-46-012074

FINAL ADJUDICATION AND ORDER

ARION R. CLAGGETT, ACTING COMMISSIONER
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

JENNIFER UNIS SULLIVAN, DMD, JD, CHAIRPERSON
STATE BOARD OF DENTISTRY

2601 North Third Street
P.O. Box 69523
Harrisburg, PA 17106-9523

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HISTORY

This matter comes before the State Board of Dentistry (Board) to determine whether the dental license and anesthesia permit- restricted I of Blanche Durand Grube, D.M.D. (Respondent) should be suspended, revoked or otherwise restricted under the Dental Law, Act of May 1, 1933, P.L. 216, No. 76 Cl. 63, *as amended*, 63 P.S. §§ 120 – 130*l*, and/or whether a civil penalty should be imposed under section 10.1 of the Dental Law, 63 P.S. § 129.1 and 63 Pa.C.S. § 3108(b)(4) and/or whether the costs of investigation should be imposed under 63 Pa.C.S. § 3108(b)(5). By Order to Show Cause filed December 6, 2022, the Commonwealth charged that the Respondent is subject to disciplinary action, including civil penalty, because she engaged in unprofessional conduct by failing to conform to the standards of acceptable and prevailing dental practice, in violation of Section 4.1(a)(8) of the Dental Law, 63 P.S. § 123.1(a)(8).

Although the Order to Show Cause was served upon Respondent by certified mail, Respondent did not file an Answer that conforms to the requirements of 1 Pa. Code § 35.37. On April 17, 2023, the Commonwealth filed a Motion to Deem Facts Admitted and Enter Default (MDFA), requesting that the Board deem Respondent to have admitted all of the factual allegations of the Order to Show Cause. The Board[1] considered the Commonwealth's MDFA at its May 12, 2023 meeting, and voted to issue an Order directing Respondent to file an Answer within 30 days. On June 30, 2023, the Commonwealth filed a Second MDFA because Respondent did not file an Answer that conforms to the requirements of 1 Pa. Code § 35.37 within 30 days. The Board considered the Commonwealth's Second MDFA at its July 14, 2023 meeting, voted to grant the Second MDFA, and then immediately deliberated on this matter. On July 18, 2023, the Board

[1] All Board members participating in the deliberation or decision in this matter have reviewed the entire record. Shawn M. Casey, D.M.D. recused himself and did not participate in the deliberation or decision in this matter.

provided Respondent with notice that it had granted the Commonwealth's Second MDFA.

On August 18, 2023, Respondent filed an objection to the Order Granting Commonwealth's Second MDFA. The Board considered the Respondent's Motion to Vacate the Order Granting Commonwealth's Second MDFA at its meeting on September 8, 2023; Respondent's Motion was denied. The Board now issues this Adjudication and Order as a final determination of the charges against Respondent.

FINDINGS OF FACT

1. Respondent holds the following license to practice as a dentist in the Commonwealth of Pennsylvania: license no. DS023621L. (Order to Show Cause at ¶1; Board records)
2. Respondent's Dental license was originally issued on August 26, 1983 and is current through March 31, 2025[2]. (Order to Show Cause at ¶2; Board records)
3. Respondent also holds the following Anesthesia Permit- Restricted I in the Commonwealth of Pennsylvania: license no. DP023621A. (Order to Show Cause at ¶3; Board records)
4. Respondent's Anesthesia Permit – Restricted I was originally issued on November 4, 1999 and is current through March 31, 2025[3]. (Order to Show Cause at ¶4; Board records)
5. Absent further action by the Board, the Respondent's licenses may be renewed, reactivated or reinstated upon the filing of the appropriate documentation and payment of the necessary fees. (Order to Show Cause at ¶5; Board records)
6. At all times pertinent to the Factual Allegations, Respondent held a license to practice as a dentist in the Commonwealth of Pennsylvania. (Order to Show Cause at ¶6; Board records).
7. Respondent's last known address on file with the Board is 810 Green Ridge Street, Scranton, PA 18509. (Order to Show Cause at ¶7; Board records).
8. Respondent entered into a dentist-patient relationship with Patients number one (1) through forty-two (42). (Order to Show Cause at ¶9)
9. Respondent rendered dental services and/or treatment to Patients number one (1) through forty-two (42) in the Commonwealth of Pennsylvania. (Order to Show Cause at ¶10)

[2] At the time that the Order to Show Cause was filed on December 6, 2022, Respondent's license was current through March 31, 2023. Board records show that Respondent's license was renewed.
[3] At the time that the Order to Show Cause was filed on December 6, 2022, Respondent's anesthesia permit was current through March 31, 2023. Board records show that Respondent's anesthesia permit was renewed.

10. On December 3, 2015, Respondent commenced a dentist-patient relationship with Patient 42. (Order to Show Cause at ¶12)

11. Patient 42 was a 51-year-old female with a history of the following:

    a. Anemia,

    b. Abnormal EKG,

    c. Not being under the care of a physician,

    d. Not aware whether she had any allergies,

    e. Blurred or tunnel vision, and

    f. Bleeding Gums.

    (Order to Show Cause at ¶13)

12. Respondent extracted Patient 42's endodontically treated teeth # 13 and 19. (Order to Show Cause at ¶15)

13. No clinical documentation existed justifying the need for extracting teeth # 13 and 19. (Order to Show Cause at ¶16)

14. Respondent removed porcelain fused to metal (PFM) crowns on Patient 42's teeth # 2, 15, 18, and 19 and replaced with non-metallic crowns. (Order to Show Cause at ¶17)

15. No clinical documentation existed justifying the removal of the PFM crowns on teeth # 2, 15, 18, and 19. (Order to Show Cause at ¶18)

16. Implants at the areas of Patient 42's teeth # 5, 15, 18, and 19 were removed. (Order to Show Cause at ¶19)

17. No clinical documentation existed justifying the removal of the implants at teeth # 5, 15, 18, and 19. (Order to Show Cause at ¶20)

18. Implants previously placed in the area of Patient 42's teeth # 29, 30, and 31 were removed without clinical justification. (Order to Show Cause at ¶21)
19. During the removal of implants in the area of teeth # 29, 30, and 31, the mental nerve was damaged, resulting in paresthesia (numbness or tingling) of the lower left lip. (Order to Show Cause at ¶22)
20. The proximity of the mental nerve to the implants was evident radiographically. (Order to Show Cause at ¶23)
21. Removal of Patient 42's implants, if indicated, should have been referred to an oral and maxillofacial surgeon to lessen the likelihood of an adverse outcome. (Order to Show Cause at ¶24)
22. Respondent did not refer Patient 42 to an oral and maxillofacial surgeon to manage the paresthesia at the time that it occurred. (Order to Show Cause at ¶25)
23. Paresthesia can sometimes be reversed if addressed promptly. (Order to Show Cause at ¶26)
24. In the absence of a referral to an oral and maxillofacial surgeon, the paresthesia suffered by Patient 42 is likely permanent. (Order to Show Cause at ¶27)
25. Respondent performed a procedure upon Patient 42 at teeth # 1, 16, 17, 20, and 32 that Respondent refers to as "Cavitation Surgery," which involves one or more of the following invasive or surgical procedures:
    a. Elevation of a flap.
    b. Penetration of cortical bone.
    c. Removal of tissue that Respondent refers to as "pathological tissue."

(Order to Show Cause at ¶¶28, 45, 72, 102)

26. Cavitation Surgery is not:

    a. A procedure recognized or identified in the professions of dentistry or medicine by this specific terminology or by any other synonymous terms.

    b. Of any therapeutic benefit for any condition or disease.

    (Order to Show Cause at ¶¶29, 46, 73, 103)

27. The procedures that Respondent offered to Patient 42 were clinically unnecessary, invasive, and offered no dental benefit. (Order to Show Cause at ¶30)

28. Respondent departed from, or failed to conform to, the standards of acceptable and prevailing dental practice in treating Patient 42. (Order to Show Cause at ¶14)

29. On May 12, 2017, Respondent commenced a dentist-patient relationship with Patient 41. (Order to Show Cause at ¶33)

30. Patient 41 was a 253 pound 52-year-old male with a history of the following:

    a. Skin cancer,

    b. Multiple traumatic injuries,

    c. Diabetes treated by metformin and glipizide, and

    d. Memory loss.

    (Order to Show Cause at ¶34)

31. Respondent removed a PFM crown on Patient 41's tooth # 8 and replaced it with a non-metallic crown. (Order to Show Cause at ¶36)

32. There was no clinical documentation justifying the removal of the PFM crown on tooth # 8. (Order to Show Cause at ¶37)

33. Respondent extracted Patient 41's previously-endodontically treated tooth # 9. (Order to Show Cause at ¶38)

34. There was no clinical documentation justifying the extraction of tooth # 9. (Order to Show Cause at ¶39)

35. Respondent removed dental amalgam on Patient 41's teeth # 2, 3, 19, 31, 32 and replaced with non-amalgam restorations. (Order to Show Cause at ¶40)

36. Respondent noted the presence of decay in the teeth where amalgam was removed. (Order to Show Cause at ¶41)

37. There is no radiographic evidence of decay at teeth # 2, 3, 19, 31, 32. (Order to Show Cause at ¶42)

38. The removal of amalgam was unnecessary. (Order to Show Cause at ¶43)

39. The removal of amalgam was not in the best interests of Patient 41. (Order to Show Cause at ¶44)

40. Respondent performed a "Cavitation Surgery" upon Patient 41 at teeth # 16, 17, and 18. (Order to Show Cause at ¶45)

41. Cavitation Surgery is not:

    a. A procedure recognized or identified in the professions of dentistry or medicine by this specific terminology or by any other synonymous terms.

    b. Of any therapeutic benefit for any condition or disease.

    (Order to Show Cause at ¶46)

42. On July 11, 2017, Patient 41 was sedated prior to treatment. (Order to Show Cause at ¶47)

43. Respondent noted that the patient was "not a great breather" and "had to increase 0_2 to 3 liters". (Order to Show Cause at ¶48)

44. On July 25, 2017, Patient 41 was administered eight and one-half (8.5) carpules of carbocaine, a local anesthetic. (Order to Show Cause at ¶49)

45. Eight and one-half (8.5) carpules of carbocaine for Patient 41 exceeds the recommended dose for local anesthesia for a single sitting. (Order to Show Cause at ¶50)

46. On July 25, 2017, Respondent administered the first dose of anesthesia to Patient 41 at 10:20 A.M. and treatment was not finished until 3:55 P.M. that same day. (Order to Show Cause at ¶51)

47. This extended treatment duration placed Patient 41 at risk of venous stasis. (Order to Show Cause at ¶52)

48. With a history of excess weight, diabetes, and difficulty breathing, Patient 41 was a poor candidate for in-office intravenous sedation. (Order to Show Cause at ¶53)

49. With a history of excess weight, diabetes, and difficulty breathing, Patient 41 was at higher risk for mortality. (Order to Show Cause at ¶54)

50. Patient 41 was not adequately monitored while under sedation for:

    a. Continuous respiration, and

    b. Proper heart function by Electrocardiogram (ECG or EKG).

    (Order to Show Cause at ¶55)

51. Respondent departed from, or failed to conform to, the standards of acceptable and prevailing dental practice in treating Patient 41. (Order to Show Cause at ¶35)

52. On February 6, 2017, Respondent commenced a dentist-patient relationship with Patient 40. (Order to Show Cause at ¶58)

53. Patient 40 was a 56-year-old male with a history of the following:

    a. Last exam by a physician occurring over 5 years prior his visit with Respondent,

    b. "Unexplained lump on chest, had cancer in chest 5 years ago…did alternative healing and cured himself. Still has lump. A lot smaller."

c. Small spots of skin cancer,

d. “Feels Brain Fog”, and

e. Occasional chest pains and occasional tachycardia.

(Order to Show Cause at ¶59)

54. Extensive serologic testing was performed on Patient 40, and Respondent marked abnormalities on the testing results. (Order to Show Cause at ¶61)

55. No referral to a physician was made pursuant to Respondent’s assessment of the serologic results. (Order to Show Cause at ¶62)

56. Hair toxicity testing was conducted on Patient 40. (Order to Show Cause at ¶63)

57. Hair toxicity testing is unrelated to the practice of dentistry, and thus constitutes an unnecessary procedure. (Order to Show Cause at ¶64)

58. Mercury vapor testing was conducted on Patient 40. (Order to Show Cause at ¶65)

59. Mercury vapor testing is unrelated to the practice of dentistry, and thus constitutes an unnecessary procedure. (Order to Show Cause at ¶66)

60. Respondent removed dental amalgam on Patient 40’s teeth # 3, 4, 5, 12, 14, 18, 19, 30, and 31 and replaced with non-amalgam restorations and an onlay in the area of tooth # 30. (Order to Show Cause at ¶67)

61. Respondent noted the presence of decay in Patient 40’s teeth where amalgam was removed. (Order to Show Cause at ¶68)

62. There is no radiographic evidence of decay at Patient 40’s teeth # 3, 4, 5, 12, 14, 18, 19, 30, and 31. (Order to Show Cause at ¶69)

63. The removal of Patient 40’s amalgam was not necessary. (Order to Show Cause at ¶70)

64. The removal of amalgam was not in the best interests of Patient 40. (Order to Show Cause at ¶71)

65. Respondent performed a "Cavitation Surgery" upon Patient 40 at teeth # 1, 16, 17 and 32. (Order to Show Cause at ¶72)

66. Respondent excised a radiopacity in the area of Patient 40's tooth # 32 but did not submit a sample of the excised tissue for pathologic examination or refer the patient to an oral and maxillofacial surgeon. (Order to Show Cause at ¶74)

67. On February 20, 2017, Patient 40 was administered nine (9) carpules of carbocaine, a local anesthetic, and 9mg of Midazolam. (Order to Show Cause at ¶75)

68. Respondent administered local anesthetic to Patient 40 in an amount that exceeded the total recommended dosage to be used in a single sitting. (Order to Show Cause at ¶76)

69. On February 20, 2017, Respondent administered the first dose of Versed to Patient 40 at approximately 10:00 A.M. and treatment was not finished until 5:10 P.M. that same day. (Order to Show Cause at ¶77)

70. This extended treatment duration placed Patient 40 at risk of venous stasis. (Order to Show Cause at ¶78)

71. Patient 40 was not adequately monitored while under sedation for:

    a. Continuous respiration, and

    b. Proper Heart function by Electrocardiogram (ECG or EKG).

    (Order to Show Cause at ¶79)

72. Respondent departed from, or failed to conform to, the standards of acceptable and prevailing dental practice in treating Patient 40. (Order to Show Cause at ¶60)

73. On May 13, 2017, Respondent commenced a dentist-patient relationship with Patient 28. (Order to Show Cause at ¶82)

74. Patient 28 was a 57-year-old female with a history of the following:

    a. Chronic Lyme disease,

    b. Daily regimen of IV Clindamycin for the management of Lyme Disease,

    c. "Carotid issues",

    d. Chest Pain,

    e. Irregular heartbeat, "off/ on",

    f. Abnormal EKG (Electrocardiogram) results, and

    g. Endocarditis (inflammation of the inner lining of the heart's chambers and valves).

    (Order to Show Cause at ¶83)

75. Respondent removed a four-unit bridge in the area of Patient 28's teeth # 2-5 without clinical justification. (Order to Show Cause at ¶85)

76. Removal of the four-unit bridge and the cavitation procedures exposed Patient 28 to the risks of bleeding, post-operative infection, and pain. (Order to Show Cause at ¶86)

77. With Patient 28's history of endocarditis, administration of additional antibiotic prophylaxis prior to treatment was required to mitigate the risk of recurrent endocarditis, in the absence of a cardiac consult stating that additional antibiotic prophylaxis was not required. (Order to Show Cause at ¶87)

78. Respondent failed to give Patient 28 additional antibiotic prophylaxis prior to treatment on May 24, 2017. (Order to Show Cause at ¶88)

79. Failure to give additional antibiotic prophylaxis prior to treatment put Patient 28 at risk of a life-threatening complication; recurrent endocarditis. (Order to Show Cause at ¶89)

80. On May 24, 2017, Patient 28 was administered seven (7) carpules of carbocaine, a local anesthetic. (Order to Show Cause at ¶90)

81. The IV sedation record for May 24, 2017 lists Patient 28's weight at 106 pounds. (Order to Show Cause at ¶91)

82. Seven (7) carpules of carbocaine for Patient 28, at a weight of 106 pounds, exceeds the recommended dose for local anesthesia for a single sitting. (Order to Show Cause at ¶92)

83. Patient 28 was not adequately monitored while under sedation for:

    a. Continuous respiration, and

    b. Proper Heart function by Electrocardiogram (ECG or EKG).

    (Order to Show Cause at ¶93)

84. Monitoring through electrocardiogram was required for Patient 28 due to Patient 28's history of irregular heartbeat and endocarditis.

    (Order to Show Cause at ¶94)

85. Respondent departed from, or failed to conform to, the standards of acceptable and prevailing dental practice in treating Patient 28. (Order to Show Cause at ¶84)

86. On April 26, 2017, Respondent commenced a dentist-patient relationship with Patient 20. (Order to Show Cause at ¶97)

87. Patient 20 was an adult 58-year-old male with a history of the following:

    a. the patient was not currently under the care of a physician,

    b. a diagnosis of head and neck cancer in December 2012,

    c. holistic cancer treatment with no chemotherapy or radiation,

    d. sore or enlarged lymph nodes,

e. a height and weight of 6 feet and 130 pounds, equating to a body mass index of 17.6,

f. 7 (seven) to 9 (nine) previous root canals,

g. difficulty speaking and swallowing, and

h. Difficulty breathing through the nose.

(Order to Show Cause at ¶98)

88. On examination, Respondent observed the following:

a. Enlargement of the left tonsillar area,

b. A lesion on the left ventral border of the tongue,

c. Bilateral cervical lymphadenopathy, and

d. Enlargement of the left submandibular gland region.

(Order to Show Cause at ¶99)

89. Patient 20's clinical presentation was consistent with advanced head and neck cancer. (Order to Show Cause at ¶100)

90. Respondent performed "Cavitation Surgery" upon Patient 20 at teeth # 1-4, 13-16, 17, 20, 29-30, and 32. (Order to Show Cause at ¶102)

91. Respondent ordered and obtained multiple tests for health conditions which are unrelated to the practice of dentistry:

a. DNA

b. Hematology.

(Order to Show Cause at ¶104)

92. Respondent extracted Patient 20's teeth # 2, 3, 14, 18, and 31. (Order to Show Cause at ¶105)

93. The extractions of teeth # 2, 3, 14, 18, and 31 were not clinically justified. (Order to Show Cause at ¶106)

94. Respondent removed crowns on Patient 20's teeth # 5 and 12. (Order to Show Cause at ¶107)

95. The removal of crowns on teeth # 5 and 12 were not clinically justified. (Order to Show Cause at ¶108)

96. Pus was drained from Patient 20's submandibular glands on May 8, 2017, and on May 10, 2017. (Order to Show Cause at ¶109)

97. Respondent administered intravenous Vitamin C to the patient. (Order to Show Cause at ¶110)

98. Vitamin C is not FDA approved as a cancer therapy. (Order to Show Cause at ¶111)

99. Serious side effects from Vitamin C administration have been reported. (Order to Show Cause at ¶112)

100. Patient 20 died on June 14, 2017, approximately one month after his last appointment with Respondent. (Order to Show Cause at ¶113)

101. Consultation with a physician should have been obtained prior to Respondent's treatment of patient 20. (Order to Show Cause at ¶114)

102. The treatment rendered to Patient 20 by Respondent was elective dental treatment. (Order to Show Cause at ¶115)

103. Patient 20 was not a candidate for elective dental treatment, given the state of his health. (Order to Show Cause at ¶116)

104. Respondent's treatment of Patient 20 risked infection, bleeding, and tumor seeding/ spreading. (Order to Show Cause at ¶117)

105. Given Patient 20's health, Respondent's treatment of Patient 20 risked compromising Patient 20's remaining quality of life. (Order to Show Cause at ¶118)

106. Respondent departed from, or failed to conform to, the standards of acceptable and prevailing dental practice in treating Patient 20. (Order to Show Cause at ¶101)

107. For Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41, Respondent ordered extensive blood-based laboratory testing. (Order to Show Cause at ¶121)

108. Respondent's ordering of blood-based laboratory testing was performed to diagnose and/or treat medical conditions or ailments. (Order to Show Cause at ¶123)

109. Respondent's ordering of blood-based laboratory testing is beyond the scope of dental practice in Pennsylvania. (Order to Show Cause at ¶122)

110. As a dentist, Respondent is not qualified to diagnose and/or treat medical conditions or ailments. (Order to Show Cause at ¶124)

111. Respondent noted abnormalities or concerns in the blood testing results for Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41. (Order to Show Cause at ¶125)

112. Respondent did not refer Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41 to medical professionals for medical diagnosis and/or treatment. (Order to Show Cause at ¶126)

113. The standard of care requires that Respondent refer Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41 to medical professionals upon noting abnormalities in their blood testing results. (Order to Show Cause at ¶127)

114. The Commonwealth incurred costs of investigation in this matter in the amount of forty-five thousand, seven hundred twenty-seven dollars and sixty cents ($45,727.60). (Order to Show Cause at ¶8).

115. On December 6, 2022, the Commonwealth filed an Order to Show Cause setting

forth the allegations that Respondent engaged in unprofessional conduct. (Board records; Case # 18-46-02952 and 18-46-012074)

116. On December 7, 2022, the Order to Show Cause was sent to, and later served on, Respondent by certified mail, return receipt requested and first-class mail, postage prepaid to 810 Green Ridge Street, Scranton, PA 18509. (Order to Show Cause at Certificate of Service)

117. The Commonwealth prepared and served on Respondent an identity key to the Order to Show Cause which provided the name of each individual identified as a patient. (Order to Show Cause at ¶9, fn. 1)

118. On December 26, 2022, Respondent requested an extension of time in which to respond to the Order to Show Cause. (December 26, 2022 email from Respondent to Department of State Prothonotary's Office; Board records; Case # 18-46-02952 and 18-46-012074)

119. On January 10, 2023, Hearing Examiner Michael Foerster granted Respondent a 30-day extension of time in which to file an Answer, which was due on February 10, 2023. (January 10, 2023 Order Granting Extension of Time to File Answer; Board records; Case # 18-46-02952 and 18-46-012074)

120. On February 10, 2023, Reverend Juan-José: Brookins filed a Private Administrative Trustee Presentment of a Private Bill of Discovery in this matter. (Private Administrative Trustee Presentment of a Private Bill of Discovery filed February 10, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

121. Reverend Brookins is not an attorney. (Board records; Case # 18-46-02952 and 18-46-012074)

122. On February 21, 2023, the Commonwealth filed a Motion to Strike Rev. Brookins' Private Bill of Discovery. (Commonwealth's Motion to Strike "Private Administrative Trustee Presentment of Private Bill of Discovery" filed February 21, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

123. On March 9, 2023, Hearing Examiner Michael Foerster granted the Commonwealth's Motion to Strike Rev. Brookins' Private Bill of Discovery and ordered Respondent to file an Answer consistent with the administrative rules within 30 days. (March 9, 2023 Order of Hearing Examiner Michael T. Foerster; Board records; Case # 18-46-02952 and 18-46-012074)

124. On April 6, 2023, Respondent filed a Pre-Trial Discovery and Inspection Pursuant to 234 Pa. Code § 573(a) of the Rules of Criminal Procedure in which Respondent requested an explanation of the Bureau of Professional and Occupational Affairs' (BPOA) jurisdiction in this matter. (Respondent's Pre-Trial Discovery and Inspection Pursuant to 234 Pa. Code § 573(a) filed April 6, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

125. On April 17, 2023, the Commonwealth filed a Motion to Deem Facts Admitted (MDFA) because Respondent did not file an Answer which conforms to the requirements of 1 Pa. Code § 35.37 within 30 days of the hearing examiner's order. (Commonwealth's Motion to Deem Facts Admitted and Enter Default filed April 17, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

126. On May 8, 2023, Respondent filed an Objection to Commonwealth's Motion to Deem Facts Admitted and Enter Default and continued to request an explanation of the BPOA's jurisdiction in this matter. (Respondent's Objection to Motion to Deem Facts

Admitted and Enter Default filed May 8, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

127. On May 24, 2023, the Board issued an Order directing Respondent to file an Answer which conforms to the requirements of 1 Pa. Code § 35.37 within 30 days. (May 23, 2023 Order Directing Respondent to File Answer Within 30 Days; Board records; Case # 18-46-02952 and 18-46-012074)

128. The May 24, 2023 Order explained the Board's jurisdiction over licensees of the Board under the Dental Law, 63 P.S. 120-130i. (May 23, 2023 Order Directing Respondent to File Answer Within 30 Days; Board records; Case # 18-46-02952 and 18-46-012074)

129. On June 29, 2023, Respondent's[4] Answer to the Order to Show Cause was filed. (Respondent-in-Error's Answer to Pennsylvania State Board of Dentistry's Order to Show Cause filed June 29, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

130. On June 30, 2023, the Commonwealth filed a Second Motion to Deem Facts Admitted (Second MDFA) because Respondent did not file an Answer that conforms to the requirements of 1 Pa. Code § 35.37 within 30 days. (Commonwealth's Second Motion to Deem Facts Admitted and Enter Default filed June 30, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

131. On July 18, 2023, the Board issued an Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default. (July 18, 2023 Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default; Board records; Case # 18-46-02952 and 18-46-012074)

132. On August 14, 2023, Respondent's Objection to State Board of Dentistry's Order

[4] In the Answer, Respondent referred to herself as "Respondent-in-Error."

Granting Motion to Deem Facts Admitted and Enter Default by Way of Plea in Abatement was filed. (Respondent's Objection to State Board of Dentistry's Order Granting Motion to Deem Facts Admitted and Enter Default by Way of Plea in Abatement filed August 14, 2023; Board records; Case # 18-46-02952 and 18-46-012074)

133. On October 19, 2023, the Board issued an Order Denying Respondent's Motion to Vacate the Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default (MDFA). (October 19, 2023 Order Denying Respondent's Motion to Vacate the Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default (MDFA); Board records; Case # 18-46-02952 and 18-46-012074)

134. Despite being given several opportunities to do so, Respondent did not file an Answer to the Order to Show Cause that conformed to the requirements of 1 Pa. Code § 35.37. (Board records, Case Nos. 18-46-02952 and 18-46-012074)

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter. (Findings of Fact numbers 1-6)
2. Respondent was afforded reasonable notice of the charges and an opportunity to be heard in accordance with the Administrative Agency Law, 2 Pa. C.S. § 504. (Findings of Fact numbers 7, 115-134)
3. Respondent is subject to discipline under section 4.1(a)(8) of the Dental Law, 63 P.S. § 123.1(a)(8) because she engaged in unprofessional conduct by failing to conform to the standard of acceptable and prevailing dental practice. (Findings of Fact numbers 8-116)
4. Respondent is subject to a civil penalty under section 10.1 of the Dental Law, 63 P.S. § 129.1 and/or 63 P.S. § 3108(b)(4) Section 5(b)(4) for violating sections 4.1(a)(8) of the Dental Law. (Findings of Fact numbers 8-113)
5. Respondent is subject to the costs of investigation under 63 P.S. § 3108(b)(5) because Respondent she violated section 4.1(a)(8) of the Dental Law, 63 P.S. § 123.1(a)(8) by engaging in unprofessional conduct. (Finding of Fact number 8-114)

DISCUSSION

The Commonwealth charged that Respondent is subject to disciplinary action under the Dental Law, Act of May 1, 1933, P.L. 216, No. 76 Cl. 63, *as amended*, 63 P.S. §§ 120 – 130*l*, and/or imposition of a civil penalty under section 10.1 of the Dental Law, 63 P.S. § 129.1 and 63 Pa.C.S. § 3108(b)(4) and/or imposition of the costs of investigation under 63 Pa.C.S. § 3108(b)(5) because Respondent violated section 4.1(a)(8) of the Dental Law, 63 P.S. § 123.1(a)(8) by engaging in unprofessional conduct.

Due process requires that "[p]arties whose rights are to be affected are entitled to be heard and, in order that they may enjoy that right, they must first be notified." *Celane v. Insurance Commissioner*, 415 A.2d 130, 132 (Pa. Cmwlth. 1980) (citation omitted). Service by mail is specifically authorized by the General Rules of Administrative Procedure, as set forth at 1 Pa. Code § 33.31. Notice should be reasonably calculated to inform a respondent of the pending action and to provide the information necessary to present objections. *Celane*, 415 A.2d at 132. Personal receipt is not required where notice has been mailed to the appropriate address. *Kobylski v. Commonwealth Milk Marketing Bd.*, 516 A.2d 75, 77 (Pa. Cmwlth. 1986).

The address that the Board has on file for Respondent is 810 Green Ridge Street, Scranton, PA 18509. On December 7, 2022, the Order to Show Cause was sent to, and later served on, Respondent by certified mail, return receipt requested and first-class mail, postage prepaid to 810 Green Ridge Street, Scranton, PA 18509. The Commonwealth prepared and served on Respondent an identity key which provided the name of each individual identified in the Order to Show Cause as a patient.

The Notice accompanying the Order to Show Cause directs Respondent to file a written answer within thirty (30) days of the date on the Order to Show Cause and sets forth the potential consequences for failure to timely file a written answer. Specifically, the factual allegations in the

Order to Show Cause may be deemed admitted and the Board will issue an Order which may impose penalties, as authorized by § 35.37 of the General Rules of Administrative Practice and Procedure, 1 Pa. Code § 35.37[5]. The Order to Show Cause also sets forth with particularity the steps necessary to request an administrative hearing.

After having received the Order to Show Cause, Respondent made a request on December 26, 2022 for an extension of time in which to respond to the Order to Show Cause. On January 10, 2023, Hearing Examiner Michael Foerster granted Respondent a 30-day extension of time in which to file an Answer, which was due on February 10, 2023.

On February 10, 2023, Reverend Juan-José: Brookins filed a Private Administrative Trustee Presentment of a Private Bill of Discovery in this matter. Reverend Brookins claimed to be a trust protector for the Restorative Health Ministries Trust and Ministerial Indigenous Nations Trust (MINT) in Mount Vernon, New York. Reverend Brookins claimed that Respondent was conducting research for the Trust. Rev. Brookins requested discovery of the basis for the Commonwealth's investigation to make sure that the Trust's proprietary property rights and privacy rights were not infringed upon. On February 21, 2023, the Commonwealth filed a Motion to Strike Rev. Brookins' Private Bill of Discovery. On March 9, 2023, Hearing Examiner Michael

[5] **§35.37. Answers to order to show cause.**

> A person upon whom an order to show cause has been served under § 35.14 (relating to orders to show cause) shall, if directed so to do, respond to the same by filing within the time specified in the order an answer in writing. The answer shall be drawn as specifically to admit or deny the allegations or charges which may be made in the order, set forth the facts upon which respondent relies and state concisely the matters of law relied upon. Mere general denials of the allegations of an order to show cause which general denials are unsupported by specific facts upon which respondent relies, will not be considered as complying with this section and may be deemed a basis for entry of a final order without hearing, unless otherwise required by statute, on the ground the response has raised no issues requiring a hearing or further proceedings. A respondent failing to file answer within the time allowed shall be deemed in default, and relevant facts stated in the order to show cause may be deemed admitted.

1 Pa. Code § 35.37

Foerster granted the Commonwealth's Motion to Strike Rev. Brookins' Private Bill of Discovery noting that the person at issue was Dr. Grube, not the Independent Review Board (IRB). It was also noted that Reverend Brookins was not an attorney. The hearing examiner ordered Respondent to file an Answer consistent with the administrative rules[6], under her signature or that of a licensed attorney, within 30 days.

On April 6, 2023, Respondent filed a Pre-Trial Discovery and Inspection Pursuant to 234 Pa. Code § 573(a) in which Respondent requested an explanation of the Bureau of Professional and Occupational Affairs' (BPOA) jurisdiction in this matter. Respondent claimed that she was involved in private intellectual property research for an Ecclesiastic Indigenous Trust entity that is protected under federally recognized Institutional Review Board (IRB). Title 234 of the Pennsylvania Code contains the Rules of Criminal Procedure. The pretrial discovery and inspection provisions of 234 Pa. Code § 573(a) fall under the Rules of Criminal Procedure. The instant matter, however, is a civil, administrative matter to which the Rules of Criminal Procedure are inapplicable.

On April 17, 2023, the Commonwealth filed a Motion to Deem Facts Admitted (MDFA) because Respondent did not file an Answer which conforms to the requirements of 1 Pa. Code § 35.37 within 30 days of the hearing examiner's order. On May 8, 2023, Respondent filed an Objection to Commonwealth's Motion to Deem Facts Admitted and Enter Default and continued to request an explanation of the BPOA's jurisdiction in this matter. Respondent claimed that she was conducting private intellectual property research at the direction of a private ecclesiastical indigenous Trust Consortium that is federally recognized by the Food and Drug Administration (FDA). On May 24, 2023, the Board issued an Order directing Respondent to file an Answer

[6] The hearing examiner's March 9, 2023 Order at footnote 5 provided Respondent with the language of 1 Pa. Code § 35.37 (relating to answers to orders to show cause).

which conforms to the requirements of 1 Pa. Code § 35.37 within 30 days. Respondent was to submit an Answer that addressed each specifically numbered allegation in the Commonwealth's Order to Show Cause. The May 24, 2023 Order also explained the Board's jurisdiction over licensees of the Board under the Dental Law, 63 P.S. 120-130i. Specifically, Respondent is a Pennsylvania licensed dentist and the allegations of the Order to Show Cause concerned her practice of dentistry in Pennsylvania.

On June 29, 2023, Respondent-in-Error's Answer to Pennsylvania State Board of Dentistry's Order to Show Cause was filed. On June 30, 2023, the Commonwealth filed a Second Motion to Deem Facts Admitted (Second MDFA) because Respondent did not file an Answer that conforms to the requirements of 1 Pa. Code § 35.37 within 30 days. Respondent-in-Error's Answer to Pennsylvania State Board of Dentistry's Order to Show Cause did not address the specifically numbered allegations in the Order to Show Cause. Consequently, on July 18, 2023, the Board issued an Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default. On August 14, 2023, Respondent's Objection to State Board of Dentistry's Order Granting Motion to Deem Facts Admitted and Enter Default by Way of Plea in Abatement was filed. On October 19, 2023, the Board issued an Order Denying Respondent's Motion to Vacate the Order Granting Commonwealth's Second Motion to Deem Facts Admitted and Enter Default (MDFA).

The Board deems Respondent to have admitted the allegations in the seven-count Order to Show Cause. The Board is satisfied from this procedural history that Respondent has been afforded adequate notice of the charges and Respondent has been afforded an opportunity to answer the charges in writing and/or through an administrative hearing. Respondent did not avail herself of the opportunity to be heard regarding the charges such that the Board may now proceed

to enter a final order in this disciplinary proceeding without a hearing. *See Celane*, 415 A.2d 130.

Counts One through Seven of the Order to Show Cause charge that Respondent is authorized to suspend or revoke, or otherwise restrict Respondent's license under section 4.1(a)(8) of the Dental Law, 63 P.S. 123.1(a)(8), and/or impose a civil penalty under section 10.1 of the Dental Law, 63 P.S. § 129.1 and 63 Pa.C.S. § 3108(b)(4) and/or impose the costs of investigation under 63 Pa.C.S. § 3108(b)(5) because Respondent engaged in unprofessional conduct by failing to conform to the standard of acceptable and prevailing dental practice.

As established by the Findings of Fact, Respondent is a Pennsylvania-licensed dentist who entered into a dentist-patient relationship with forty-two (42) patients, identified as Patients 1-42. Respondent rendered dental services and/or treatment to these patients in the Commonwealth of Pennsylvania. Counts One through Five chronical Respondent's treatment of five specific patients (Patients 42, 41, 40, 28, and 20) who each presented with their own history of medical issues, including cancer, diabetes, Lyme disease, and abnormal EKG. Respondent performed a number of procedures on these patients with no clinical documentation justifying the need for the procedures. For Patients 42 and 41, Respondent removed porcelain fused to metal (PFM) crowns from their teeth and replaced them with non-metallic crowns. For Patients 42 and 41, Respondent extracted endodontically treated teeth. For Patients 41 and 40, Respondent removed dental amalgam with no radiologic evidence of tooth decay. For Patients 41, 40, and 28, Respondent administered local anesthesia at doses that exceeded the recommended dose for a single sitting, placing the patients at risk of venous stasis[7]. Patients 41, 40, and 28 were not adequately monitored while under sedation for continuous respiration and proper heart function (ECG or EKG).

For Patients 42, 41, 40, and 20, Respondent performed what she refers to as "Cavitation

[7] Venous statis is a chronic inflammatory skin disease caused by the pooling of blood in the legs due to poor blood circulation.

Surgery," which involves one or more of the following invasive or surgical procedures:

a. Elevation of a flap.

b. Penetration of cortical bone.

c. Removal of tissue that Respondent refers to as "pathological tissue."

Cavitation Surgery is not a procedure recognized or identified in the professions of dentistry or medicine by this specific terminology or by any other synonymous terms. Cavitation surgery is not of any therapeutic benefit for any condition or disease.

Concerning Patient 28, Respondent removed a four-unit bridge in the area of teeth # 2-5 without clinical justification. Removal of the four-unit bridge, as well as the cavitation procedures, exposed Patient 28 to the risks of bleeding, post-operative infection, and pain. With Patient 28's medical history of endocarditis, administration of additional antibiotic prophylaxis prior to treatment was required to mitigate the risk of recurrent endocarditis, in the absence of a cardiac consult stating that additional antibiotic prophylaxis was not required. Respondent failed to give Patient 28 additional antibiotic prophylaxis prior to treatment on May 24, 2017. Failure to give additional antibiotic prophylaxis prior to treatment put Patient 28 at risk of a life-threatening complication, recurrent endocarditis.

Patient 20 had a history of head and neck cancer. Patient 20 had received holistic cancer treatment with no chemotherapy or radiation. Respondent entered into a dentist-patient relationship with Patient 20 on April 26, 2017. Respondent extracted teeth # 2, 3, 14, 18, and 31. The extractions of teeth # 2, 3, 14, 18, and 31 were not clinically justified. Respondent removed crowns on Patient 20's teeth # 5 and 12. The removal of crowns on teeth # 5 and 12 were not clinically justified. Pus was drained from Patient 20's submandibular glands on May 8, 2017 and on May 10, 2017. Respondent administered intravenous Vitamin C to the patient. Vitamin C is

not FDA approved as a cancer therapy. Serious side effects from Vitamin C administration have been reported. The treatment Respondent rendered to Patient 20 was elective dental treatment. Patient 20 was not a candidate for elective dental treatment, given the state of his health. For all the above reasons, Counts One through Five of the Order to Show Cause are sustained.

Count Six alleges that Respondent engaged in unprofessional conduct by ordering unnecessary lab tests. For Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41, Respondent ordered extensive blood-based laboratory testing. Respondent's ordering of blood-based laboratory testing was performed to diagnose and/or treat medical conditions or ailments. Respondent's ordering of blood-based laboratory testing is beyond the scope of dental practice in Pennsylvania. As a dentist, Respondent is not qualified to diagnose and/or treat medical conditions or ailments. Count Six, therefore, is sustained.

Count Seven alleges that Respondent engaged in unprofessional conduct by failing to make appropriate medical referrals. Respondent, albeit while acting outside of her scope of practice, noted abnormalities or concerns in the blood testing results for Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41. Respondent did not refer these patients to medical professionals for medical diagnosis and/or treatment. The standard of care requires that Respondent refer Patients 2, 3, 7, 19, 25, 28, 37, 40, and 41 to medical professionals upon noting abnormalities in their blood testing results. Count Seven, therefore, is sustained.

The facts deemed admitted establish the violation and the Board must determine an appropriate sanction. The Board considers the seriousness of the offense and any mitigating evidence when determining a penalty. Respondent did not provide the Board with any mitigating evidence, despite having ample opportunity to do so. Section 4.1(a)(8) of the Dental Law, 63 P.S. § 4.1(a)(8), states that "unprofessional conduct" includes "any departure from, or failure to

conform to, the standards of acceptable and prevailing dental or dental hygiene practice… in which proceeding actual injury to the patient need not be established."

In the current matter, Respondent demonstrated a flagrant disregard for carrying out her responsibility to conform to the standards of acceptable and prevailing dental practice. Respondent performed dental procedures on several patients with no clinical documentation justifying the need for the procedures, including the removal of teeth, the removal of PFM crowns, and cavitation surgery. In the case of Patient 42, Respondent removed implants from teeth without clinical justification. During the removal of implants, Patient 42's mental nerve was damaged, resulting in paresthesia (numbness or tingling) of the lower left lip. If removal of implants had been clinically indicated, Patient 42 should have been referred to an oral and maxillofacial surgeon to perform the procedure in order to lessen the likelihood of an adverse outcome. In the absence of a referral to an oral and maxillofacial surgeon, the paresthesia suffered by Patient 42 is likely permanent.

Respondent administered local anesthesia to patients at doses that exceeded the recommended dose for a single sitting, placing the patients at risk of venous stasis. The patients were not adequately monitored while under sedation for continuous respiration and proper heart function (ECG or EKG), which placed their health at risk. In addition, Respondent ordered unnecessary lab tests and failed to make appropriate medical referrals. In the case of Patient 20, Respondent should have consulted with a physician prior to conducting dental treatment. Patient 20 had a history of head and neck cancer and had received holistic cancer treatment with no chemotherapy or radiation. Respondent extracted five teeth and two crowns from Patient 20 with no clinical justification. Pus was drained from Patient 20's submandibular glands on two occasions. Respondent administered intravenous Vitamin C, which is not an FDA approved cancer

therapy as serious side effects have been reported. Respondent's treatment of Patient 20 risked infection, bleeding, and tumor seeding/spreading. Given Patient 20's health, Respondent's treatment of Patient 20 also risked compromising Patient 20's remaining quality of life. Sadly, Patient 20 died on June 14, 2017.

Respondent, as a licensed dentist, was responsible for ensuring that she acted in a professional manner and met the standard of care for the provision of dental services to patients. Respondent's actions posed a significant risk to the health and safety of multiple patients. Therefore, to protect the public and discourage Respondent and others from falling below the standards of acceptable and prevailing dental practice, the Board indefinitely suspends for no less than three years Respondent's dental license and anesthesia permit- restricted I, levies a $10,500 civil penalty ($1,500 for each count of the OSC), and assesses $45,727.60 in the costs of investigation against Respondent. In addition, Respondent is required to complete a minimum of four (4) hours of remedial continuing education in each of the following areas of concern, as revealed by Respondent's conduct: anesthesia, dental ethics, diagnosis, and oral surgery.

Wherefore, the Board issues the following Order:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF DENTISTRY

Commonwealth of Pennsylvania,	:	
Bureau of Professional and	:	
Occupational Affairs	:	
	:	**Case Nos. 18-46-02952**
v.	:	**18-46-012074**
	:	
Blanche Durand Grube, D.M.D.,	:	
Respondent	:	

FINAL ORDER

AND NOW, this 16th day of January, 2024, the State Board of Dentistry, having duly met and considered the entire record and based upon the foregoing Findings of Fact, Conclusions of Law and Discussion, hereby **INDEFINITELY SUSPENDS,** for a period of **NO LESS THAN THREE YEARS,** the dentist license and anesthesia permit- restricted I of Respondent, Blanche Durand Grube, D.M.D., license number DS023621L and permit number DP023621A, levies a **CIVIL PENALTY** in the amount of **TEN THOUSAND, FIVE HUNDRED DOLLARS ($10,500),** and assesses the **COSTS OF INVESTIGATION** in the amount of **FORTY-FIVE THOUSAND, SEVEN HUNDRED TWENTY-SEVEN DOLLARS AND SIXTY CENTS ($45,727.60)** on Respondent. Respondent must complete a minimum of four (4) hours of remedial continuing education in each of the following areas: anesthesia, dental ethics, diagnosis, and oral surgery

Respondent shall **IMMEDIATELY CEASE AND DESIST** from engaging in the practice of dentistry in Pennsylvania. Respondent shall surrender her dentist license (bearing issuance date of August 26, 1983) and current license documents to the Board.

Respondent shall pay the civil penalty and costs of investigation in the form of a certified

check, cashier's check, money order, or attorney's draft payable to "Commonwealth of Pennsylvania." The full amount of the civil penalty as well as the licensure documents, including dentist license, wall certificate, and wallet card, shall be delivered to:

Board Counsel
State Board of Dentistry
P.O. Box 69523
Harrisburg, PA 17106-9523

If Respondent fails to pay the civil penalty and costs of investigation, the Board will refer the matter to the Office of Attorney General for appropriate action. The Board will not reinstate Respondent's license if the civil penalty and costs of investigation have not been paid in full.

Respondent may petition the Board for reinstatement of his license to non-suspended, expired status. Along with the petition, Respondent shall submit a verification that she has paid the civil penalty and costs of investigation in full, completed a minimum of four (4) hours of continuing education in each subject of anesthesia, dental ethics, diagnosis, and oral surgery, and has not practiced in the Commonwealth of Pennsylvania in violation of this order. After the scheduling of a hearing pursuant to said petition, Respondent shall appear before the Board, or its designee, and establish her fitness to resume practice as a dentist.

This Order is effective immediately. The sanction imposed is effective February 15, 2024 (30 days after the mailing of this Order).

BY ORDER:

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

ARION R. CLAGGETT
ACTING COMMISSIONER

STATE BOARD OF DENTISTRY

JENNIFER UNIS SULLIVAN, DMD, JD
CHAIRPERSON

Respondent: Tracking # 9489 0090 0027 6582 3570 88	Blanche Durand Grube, D.M.D. 810 Green Ridge Street Scranton, PA 18509
Commonwealth's Attorney:	Gregory S. Liero, Esquire
Board Counsel:	Ronald K. Rouse, Esquire
Date of Mailing:	January 16, 2024

NOTICE

The attached Final Order represents the final agency decision in this matter. It may be appealed to the Commonwealth Court of Pennsylvania by the filing of a Petition for Review with that Court within 30 days after the entry of the order in accordance with the Pennsylvania Rules of Appellate Procedure. See Chapter 15 of the Pennsylvania Rules of Appellate Procedure entitled "Judicial Review of Governmental Determinations," Pa. R.A.P 1501 – 1561. Please note: An order is entered on the date it is mailed. If you take an appeal to the Commonwealth Court, you must serve the Board with a copy of your Petition for Review. The agency contact for receiving service of such an appeal is:

Board Counsel
P.O. Box 69523
Harrisburg, PA 17106-9523

The name of the individual Board Counsel is identified on the Final Order.