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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER LS9304052DEN
SUSANN BORDINI NORWICK, D.D.S., RESPONDENT.	:	

The State of Wisconsin, Dentistry Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Dentistry Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 5 day of July 1994.

Thomas G Brandt DDS

STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

SUSANN BORDINI NORWICK, D.D.S. LS9304052DEN

Respondent

PROPOSED DECISION

The parties to this matter for the purposes of Wis. Stats. sec. 227.53 are:

Susann Bordini Norwick, D.D.S.
2727 North Grandview Boulevard, Suite 206
Waukesha, WI 53188

State of Wisconsin
Dentistry Examining Board
1400 East Washington Avenue
Madison, WI 53708-8935

State of Wisconsin
Department of Regulation & Licensing
1400 East Washington Avenue
Madison, WI 53708-8935

A hearing in this matter was conducted on December 20 & 21, 1993, at 1400 East Washington Avenue, Madison, Wisconsin. The Division of Enforcement appeared by Attorney James W. Harris. Dr. Norwick appeared in person and by Attorney Paul J. Kelly.

Based upon the entire record in this matter, the administrative law judge recommends that the Dentistry Examining Board adopt as its final decision in the matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Susann Bordini Norwick, D.D.S. (Dr. Norwick), 2727 North Grandview Boulevard, Suite 206, Waukesha, WI 53188, is licensed to practice dentistry in the State of Wisconsin by license #2173, originally issued on September 6, 1978.

2. Dr. Norwick specializes in pediatric dentistry, including the practice of orthodontics. She is not, however, board certified in orthodontics.

3. Dr. Norwick first saw female patient LB on September 27, 1983. LB was then nine years of age. At the time of the first visit, Dr. Norwick diagnosed a Class II, Division II malocclusion, with an overbite of fifty percent, and an overjet of four millimeters. LB had crowding of both the upper and lower areas and the midline was deviated to the right three millimeters.

4. When LB's parents decided to go forward with orthodontic treatment, Dr. Norwick, on October 26, 1983, completed diagnostic studies. Diagnostic models were made, photographs were taken, and cephlametric and panoramic x-rays were done.

5. After receipt of the x-rays and models, Dr. Norwick formulated a treatment plan for LB. First, it was anticipated that a "two-by-four" would be fitted (two bands on the molars; four incisor brackets) to bring the incisors into better alignment. Second, it was proposed that the malocclusion be corrected through the use of either a distalizing arch with a bite plate and lower lingual holding arch; or the use of removable appliances consisting of an upper Schwartz, a lower Jackson and a bionator. Third, it was proposed that depending on the growth pattern of new teeth, full straight wire braces might be necessary.

6. The two-by four was fitted on December 13, 1983, and the lower Jackson was fitted on April 16, 1983. At the time of fitting the lower Jackson, an upper Schwartz was not deemed necessary because straight wire fixed appliances were satisfactorily expanding the upper arch.

7. On March 15, 1985, the lower Jackson was removed with the notation "Not working due to all new teeth." On August 2, 1985 and September 3, 1985, a new diagnostic study was done, and a revised treatment plan was formulated. At that time LB was diagnosed as having a Class II malocclusion on the right and between a Class I and Class II on the left, approximately five millimeter overjet and a 50% overbite. The midline remained deviated to the right. The treatment plan states "Bring upper incisors forward more, then orthopedic corrector. Phase II, orthopedic corrector; and phase III, SW if necessary."

8. A bionator was installed on November 29, 1985, and adjusted on December 20, 1985 and January 14, 1986. The record for February 7, 1986, indicates that the bionator was "starting to crack in plastic on the left side." A new bionator was inserted on April 24, 1986, and, on May 16, 1986, the record indicates that LB was wearing the appliance to bed only once per week. On June 16, 1986, it is noted that the second bionator had developed a crack and, on July 8, 1986, it is noted that LB was not wearing the bionator at night at all.

9. The entry in LB's records for July 22, 1986, states that she had broken the bionator near the canine area completely and that the appliance was unwearable. Impressions for a third bionator were taken at that time, and the new appliance was inserted on August 12, 1986.

10. The note for November 6, 1986 states: "Patient wearing bio only occasionally, every other day, or so she says. She says she'd prefer to wear fixed appliances." At that point in time, there had been little or no progress in widening the lower arch and a decision was made to install fixed appliances and a Wilson distalizing appliance. On November 25, 1986, a cephlametric x-ray, models and photographs were obtained, and fixed brackets were fitted on December 2, 1986.

11. On April 1, 1987, the Wilson arch was fitted. On August 4, 1987, a Nance appliance was inserted to the upper arch. On August 7, the Nance was removed because of an ulcer, and was not reinserted until August 24, 1987, because of a missed appointment. The resulting relapse required refitting the Wilson on October 13, 1987. On March 21, 1988, a Pletcher spring was inserted.

12. For the remainder of 1988, and through June of 1989, the appliances were periodically adjusted. At that point, a note dated June 10, 1989, states: "Close spaces upper anterior # 7 and 8 area. Told mom [LB] is about as good as she will get -- no more retraction of the upper anteriors possible without extracting bicuspids which we don't want to do because of profile considerations. I wish bionator would have worked better to advance lower jaw to effect a better profile and overjet situation, but she didn't wear it well. Continue to align lower incisors while slenderizing bicuspids and canines. Told mom [LB] may need to wear retainer very long time or forever due to previous position of lower incisors."

13. On July 10, 1989, the lower left bicuspids were slenderized. On September 25, 1989, the brackets were removed and, on September 28, 1989, upper and lower retainers were inserted.

14. At the time active orthodontic treatment by Dr. Norwick was completed in September, 1989, a significant orthodontic correction had been accomplished.

15. During the remainder of 1989 and through 1990, LB failed to wear the retainer on a regular basis. A diagnostic model done on November 29, 1990, by Richard E. Offerman, D.D.S., who provided orthodontic care to LB beginning on November 9, 1990, reveals shifting of the dentition as compared to Dr. Norwick's model prepared on September 28, 1989. Alignment of the lower incisors had worsened with marked overlap between the lower right central incisor and the lateral incisor to the right. The lateral incisor and bicuspid on the lower right had become displaced lingually in relation to adjoining teeth.

16. Throughout the course of Dr. Norwick's orthodontic treatment of LB, that patient's dental record establishes consistent problems with her cooperating in the treatment regimen. Notations in that regard include the following:

> 9/19/84 . . . didn't bring lower (Jackson) along . . . .
> 10/10/84 . . . not sleeping with Jackson in . . .
> 3/15/85 . . . Lower Jackson not working . . . .
> 3/20/86 . . . not wearing bionator at bedtime . . . .

5/16/86 . . . wearing to bed only one time per week . . . .
7/8/86 . . . not wearing any nights to sleep . . . .
7/22/86 . . . [LB] broke [bionator] . . . completely . . . .
11/6/86 . . . patient wearing bionator only occasionally . . . .
12/23/87 . . . gum/taffy all over . . . .
3/1/88 . . . wearing elastics?
6/21/88 . . . told to watch for certain foods; also - wear elastic!
6/28/88 . . . wear elastics . . . .
9/12/88 . . . wear elastic - change 3X/day . . . .
10/3/88 . . . keep on elastics.
3/9/89 . . . keep on elastics & change lower elastics . . . .
3/23/89 . . . keep on rubber bands?
5/25/89 . . . keep wearing rubber bands . . .

17. The relatively long period of orthodontic treatment with less than perfect orthodontic correction was a result attributable in large measure to substantial lapses in LB's cooperation with treatment.

18. On June 19, 1989, Dr. Norwick first saw male patient JA, who was at that time age 13. Dr. Norwick conducted an orthodontic evaluation and consulted with JA's mother. Records were obtained from JA's previous dentist and, on September 7, 1990, at a time when JA was age 14.11, a panoramic x-ray, cephlametric x-ray, diagnostic models and photos were obtained, followed by a consultation with JA's mother on September 17, 1990.

19. JA's orthodontic condition at the time of the September, 1990, evaluation included a finding that premature loss of the upper left baby canine resulted in shifting of the upper midline to the left and of the left upper posterior molars forward. Consequently, tooth #11, the left upper canine, was blocked out of the upper arch and erupted laterally through the buccal gingiva.

20. In September, 1990, Dr. Norwick formulated a treatment plan calling for two treatment alternatives. The first involved extraction of at least the two upper third molars, and use of a removable Setlin with bite plate to distalize the upper left quadrant, with the possible need to slenderize the upper bicuspids, which were noted to be of large size. The alternative plan called for extraction of upper and lower bicuspids and correcting the molars or, as a last resort, extracting the upper left first bicuspid only. The second phase of treatment in either case was to include the use of straight wire fixed appliances to bring all teeth into alignment.

21. Orthodontic treatment without extraction of one or more bicuspids would have been a difficult treatment approach with less than substantial chance of success but which, if successful, would have resulted in cosmetic advantages.

22. Dr. Norwick made a referral to Ronald Nellen, D.D.S., a dental surgeon, for possible removal of JA's wisdom teeth. Dr. Nellen recommended to JA's parents that all four wisdom teeth be removed, and they were extracted on October 8, 1990.

23. Dr. Norwick ordered and received the Cetlin appliance. Orthodontic treatment did not, however, go forward.

24. As constructed, the appliance intended for use by Dr. Norwick for distalizing the teeth posterior to tooth #11 would probably have been ineffective for that purpose and would have served essentially to retain those teeth in their asymmetrical positions.

CONCLUSIONS OF LAW

1. The Dentistry Examining Board has jurisdiction in this matter pursuant to sec. 447.07, Stats.

2. There is insufficient evidence to conclude that Dr. Norwick's orthodontic care provided to patient LB indicates a lack of knowledge of, an inability to apply or the negligent operation of, principles or skills of dentistry, in violation of sec. 447.07(3)(h), Stats.; engaging in a practice which constitutes a substantial danger to the health, welfare or safety of a patient or the public, in violation of DE 5.02(1); practicing or attempting to practice while unable to do so with reasonable skill and safety to patients, in violation of sec. DE 5.02(2); or practicing in a manner which substantially departs from the standard of care ordinarily exercised by a dentist which harmed or could have harmed a patient, in violation of sec. DE 5.02(5). Accordingly, there is insufficient evidence to establish that in her treatment of patient LB, Dr. Norwick engaged in unprofessional conduct in violation of sec. 447.07(3)(a).

3. There is insufficient evidence to conclude that Dr. Norwick's treatment of patient JA, including the formulation of the treatment plan, the referral of patient JA to Ronald Nellen, D.D.S., a dental surgeon, for evaluation whether JA's wisdom teeth should be removed, and the intended insertion of an appliance for the purpose of distalizing the teeth posterior to tooth #11 which may have been ineffective for that purpose, constituted conduct that indicates a lack of knowledge of, an inability to apply or the negligent operation of, principles or skills of dentistry, in violation of sec. 447.07(3)(a), Stats.; or practicing in a manner which substantially departs from the standard of care ordinarily exercised by a dentist which harmed or could have harmed a patient, in violation of sec. DE 5.02(5). There is therefore insufficient evidence to establish that in her treatment of patient JA, Dr. Norwick engaged in unprofessional conduct in violation of sec. 447.07(3)(a), Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that the Matter of Disciplinary Proceedings Against Susann Bordini Norwick, D.D.S. be, and hereby is, dismissed.

OPINION

I. Patient LB

Dr. Norwick first saw patient LB, then a girl of nine years, on September 27, 1983. An orthodontic evaluation revealed a Class II, Division II malocclusion, a fifty percent overbite, four millimeters of overjet, crowding of both the upper and lower anterior teeth and midline deviation of three millimeters. Diagnostic studies were started and a treatment plan was formulated. (Exh. 10). Phase one of the treatment, which extended over a period of approximately 22 months from December, 1983, until October, 1985, involved use of an upper fixed appliance to bring the incisors into alignment, and a lower removable appliance to assist in lower arch development.

During the initial phase of treatment, there was some evidence of less than full compliance with use of the removable appliance, with the patient record indicating that LB showed up for an appointment without the appliance in September, 1984, and indicating in October, 1984, that LB told Dr. Norwick that she was not wearing the appliance at night. That there had been limited progress during this phase of treatment was confirmed when a new diagnostic study was done in September, 1985. There was some improvement of the malocclusion on the left, but the other orthodontic problems remained largely the same.

The second phase of treatment involved the use of a removable appliance or "bionator" to redirect jaw growth. Again, there is indication in the patient record of lack of patient cooperation, including reports of sporadic use of the appliance and damage to the appliance which required its replacement on two occasions. In November, 1986, the patient expressed a preference for fixed appliances, and a third diagnostic study was conducted in that month. Again, little progress had been made, though there was apparently some reduction in the overjet noted.

The third phase of treatment consisted of full appliance therapy, with fixed appliances being fitted in December, 1986, a Wilson distalizing appliance being fitted in April, 1987, and a Nance appliance being fitted the following August. From that point until June, 1989, treatment consisted primarily of periodic adjustment of the appliances, with one relapse noted resulting from removal of the Nance appliance because of an ulcer and failure to reinsert it on a timely basis because of a missed appointment.

On July 10, 1989, the lower left bicuspids were slenderized and, in late September, 1989, the brackets were removed and retainers were inserted. At that time, LB's orthodontic condition was substantially improved and esthetically pleasing, as demonstrated by the diagnostic model dated September 28, 1989, (Exh. 8) [1] and the photographs of LB taken on that date (Exh. 15). Also on September 28, upper and lower retainers were inserted. There is satisfactory evidence that LB

[1]Examination of the 1989 model reveals that the upper contour of the lower incisors has apparently been modified. The circumstances of that seeming modification are unknown, but the record reflects that the model in evidence was a recreation of the original model prepared at the request of complainant for these proceedings (tr., p. 197). In any event, it would appear that there has been no alteration in terms of the position of the teeth (tr., pp. 333-335).

did not wear the retainers as instructed, for the diagnostic model prepared by Dr. Offerman approximately one year later shows that the front lower incisors had shifted considerably.

Based on the foregoing facts, complainant asserts that Dr. Norwick engaged in practice which indicates a lack of knowledge of, an inability to apply or the negligent operation of, principles or skills of dentistry; engaged in a practice which constitutes a substantial danger to the health, welfare or safety of the patient; practiced or attempted to practice while unable to do so with reasonable skill and safety to patients; and practiced in a manner which substantially departs from the standard of care ordinarily exercised by a dentist which harmed or could have harmed the patient. That assertion is based primarily on the testimony of two expert witnesses, Dr. Richard E. Offerman, D.D.S., who assumed LB's orthodontic care in November, 1990, and Raymond C. Thurow, D.D.S. Their testimony criticized practically every aspect of Dr. Norwick's treatment of LB, including the fact that she didn't abandon the effort to effect a good orthodontic result before she did. Dr. Thurow's written summary of Dr. Norwick's treatment, found at Exhibit 34, summarizes the position of complainant's expert as follows:

> The record clearly shows that this patient has been substantially injured by the treatment rendered by Dr. Norwick. The most severe is the root absorption and alveolar recession involving the lower central incisors. This is an admittedly difficult case, but should have been recognized from the start and the treatment planned accordingly. The attempted correction was an heroic effort to fit teeth into an inadequate mandible that was clearly doomed from the start. The damage involving the lower central incisors was exacerbated by the failure to align them with the adjacent teeth leaving them exposed to concentrated lip pressure. Even with the faulty treatment plan, if the treatment had been adequately executed and monitored as it should be done, the course of treatment could have been revised before the problems had progressed to such severe levels.

The appropriate treatment from Dr. Thurow's perspective would have been initial use of removable appliances to improve jaw relationships while the jaws were still growing, and thereafter "fitting the teeth to the jaws as you have them and there we're looking at -- increasingly at extraction as a necessary approach to accommodate the teeth and jaw structure that we have at that time." (tr. p. 169) Dr. Thurow disagreed with the proposition that extraction orthodontics would have had a compromising affect on LB's facial profile, and he asserted that an extraction approach would have minimized or avoided the problems suggested in his summary.

Dr. Offerman in his testimony agreed with Dr. Thurow that root resorption had occurred (tr., p. 23). He also agreed with Dr. Thurow that the proper approach was extraction orthodontics (tr. pp. 28-30). While conceding that tooth remodeling was something that all orthodontists do, he disagreed with Dr. Norwick's choice of teeth (tr. pp. 25-26). Dr. Offerman, while conceding the appropriateness of utilizing removable appliances in orthodontics generally, expressed doubt as to their effectiveness.

> I would prefer to utilize a fixed appliance that has a light continuous forces [sic] that are in there 24 hours a day, seven days a week, doesn't take Sunday off or Saturdays off or when you go to the school dance or any other time until the job is complete (Offerman dep., p. 36).

Q. (by Mr. Kelly) Do you use Cetlin appliances?
A. No, not specifically, no.
Q. Why not?
A. Because I'm more comfortable with fixed appliances.
Q. But you are aware that the use of Cetlin appliances is being taught in dental schools around the country, aren't you?
A. Especially at his (Offerman dep., p.121).

It's my clinical opinion, having used the [bionator] that the appliance forces the mandible forward, that the musculature that controls mandibular movement is retrained or reprogrammed, The muscles are actually lengthened . . . Then I find after six months or so, the muscles go back to their original length, and it takes the mandible back again, and we're kind of back where we started from. That is my opinion (Offerman dep., p. 44).

Dr. Thurow was not similarly reluctant in his acceptance of removable appliances, and in fact agreed that the initial stages of treatment were appropriate. Moreover, he ultimately conceded that even Dr. Norwick's second phase of treatment was not inappropriate. After testifying that he had "no quarrel with the initial steps of treatment," but rather that it was the later stages that he had a problem with (tr., p 203), Dr. Thurow testified as follows (tr., p. 213):

Q. Are you able to determine, given that you have no problem with the early phase of treatment, whether successful use of the bionator would have accomplished an appropriate orthodontic correction for [LB]?

A. I can't say that with certainty, no.

Q. Would it then have been unreasonable, given that you can't say it with certainty, for Dr. Norwick to have been optimistic about the use of a bionator in this patient?

A. Well, as I mentioned before, with her track record with removables, I wouldn't have been too optimistic.

Q. But had there been compliance, the bionator is something could have worked; correct?

A. It might have.

Q. And it wouldn't be below minimum standards of care for Dr. Norwick to have felt that at that time, that it might have worked; correct?

A. No, that's right.

Dr. Norwick explained her non-extraction treatment plan as being based on cosmetic considerations:

> On the 8/2/85 cephalometric charting, you'll notice four out of the five indicators on the top are in what is called brachycephalic measurement. Mesocephalic is someone who has an equally proportioned face as it should be. Dolichocephaloc would be someone like Dustin Hoffman who's got a longer, narrower face. Brachycephalic is someone like Robert Redford who has a broader, wider face, shorter. All right.
>
> On people that have a shorter face , the one thing you don't want to do is extract, because when you take teeth out you're going to close down more.. So -- I don't think anyone would have extracted at this stage (tr., pp. 325-326).

Respondent's expert, Ronald Rose, D.D.S., agreed that cosmetic considerations were an important factor in establishing appropriate orthodontic treatment of LB.

> . . . [A]lthough I've never seen this patient in real life, based on -- on the photographs of the patient and the -- the soft tissue and facial features of this patient, if she could be treated and resolve the malocclusion on a non-extraction basis, knowing what the other proportions of her facial features are, that that would be extremely beneficial to her overall appearance, both now as a teenager and maybe even more importantly, as she aged and matured as a woman.
>
> . . . routinely the extractions that this patient would have would be a four bicuspid extraction, which is a significant amount of dental tissue for teeth, and she would have a much smaller denture -- her total occlusion and denture of teeth with extractions would be very much smaller and more constricted, would not support her facial features as well as the full complement of all her teeth do (tr., pp. 251-252).

Dr. Rose strongly disagreed with Drs. Thurow and Offerman that extraction would not have had a deleterious effect on LB's appearance, and testified as to the growing tendency of younger orthodontic practitioners to avoid extraction if at all possible (tr., pp. 243-244).

On the question of the results of Dr. Norwick's orthodontic treatment, and LB's orthodontic status in September, 1989, Dr. Offerman, observing the September, 1989 model for the first time at hearing, stated "As represented by these models, there's a fair occlusion here. The bite is still a little too deep, but these models don't look too bad, if they're [LB's]. . . . (Offerman deposition, p.55)[2] Dr. Thurow testified that it appeared that the lower right incisor appears in the photographs taken at that time to be a little more lingual in the photograph but that he couldn't be certain. He conceded that other than that the photograph appeared similar to the model (tr., p. 198). He further conceded that the loss of tooth alignment between the termination of treatment by Dr. Norwick and the commencement of treatment by Dr. Offerman a year later could be caused by LB's failure to wear the retainers (tr., p. 200).

Dr. Rose, as might be expected, was enthusiastic over the result:

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[2]The Offerman transcript was admitted into evidence and is to be considered to the same extent as if he had testified at the hearing. Video tapes of the deposition are also in the record, and the law judge has viewed substantial parts of the video tapes, including the entire cross-examination, for the purpose of evaluating witness demeanor.

> There is no question that in looking at the post-treatment study models and the post-treatment photographs, that the class two malocclusion has been corrected; the deep overbite has been addressed and -- has been helped; that the alleviation of the tooth mass arc length discrepancy, which is the crowding, has been greatly corrected, and that she has a result, to me, within the boundaries and the makeup of the individual patient, is certainly an acceptable result, and in view of the fact that the result has been obtained on a non-extraction basis and knowing, in my opinion, the importance of non-extraction orthodontics as related to her overall appearance, has been truly a remarkable and substantial accomplishment on behalf of a doctor who would be willing to go through the effort and diligence that it would take to obtain this kind of a result on a non-extraction basis . . . (tr., p. 274).

I conclude that the difference of opinion between complainant's experts and respondent and her expert has much more to do with philosophy than with competence, and the preponderance of evidence does not support the conclusion that Dr. Norwick's treatment approach fell below the minimum standards of the dental profession.

Nor may it be concluded that Dr. Norwick's orthodontic treatment was responsible for damage to LB's lower anterior root system. Dr. Thurow testified on cross examination that he had no knowledge of the condition of LB's teeth today, and no knowledge whether her front incisors were loose. Asked whether root resorption and loss of bone could occur as one of the consequences of even the best of care, Dr. Thurow responded "It can, yes." In response to further questioning, Dr. Thurow testified that such a result could come about through poor hygiene, that roots may resorb in response to pressure or even spontaneously, and that he has experienced loss of bone and root resorption in his patients. He conceded that the prominence of roots noted in the 1985 photographs which led to his conclusions may or may not have been similarly prominent in the photographs taken at the start of treatment because the lower lip was not sufficiently retracted to observe the roots in the first photographs.

Moreover, while It was uncontested in this record that some root resorption had occurred as a sequela to orthodontic treatment, and that failure of the patient to fully cooperate during the course of treatment would have exacerbated that process, Dr. Norwick strongly denied that the prominence of lateral roots had anything to do with bone loss:

> Q. (by Mr. Kelly) Did you ever detect any mobility?
>
> A. No.
>
> Q. Are you aware of anyone ever detecting mobility?
>
> A. On each and every one of the exams by the oral surgeon and the other orthodontist involved, there was zero mobility noted on those teeth. There was no mobility whatsoever (tr., p. 336).

The record supports Dr. Norwick's statement, including the testimony of Dr. Rose who, upon examining the post-treatment panoramic x-ray, testified:

> It's a post-treatment panoramic x-ray that shows a film of the upper and lower jaws and teeth. And it shows the lower incisors as having a remarkably shorter root length than the lateral incisors. And this has always been the case. To truly diagnose bone, it would be better and easier to have a specific periapical view, but as best I can see bone tissue on this panoramic, there's nothing unusual about it other than the two centrals have shorter root length than the two laterals (tr., pp 272-273).

There is thus insufficient evidence to establish that either Dr. Norwick's treatment plan or its execution was responsible for alveolar recession.

Complainant's experts also criticized Dr. Norwick's having referred LB to an oral surgeon, Dr. Nellen, for evaluation, which referral resulted in extraction of all four third molars. When Dr. Offerman was asked whether removal of LB's lower wisdom teeth would provide more room for correction of the lower anterior teeth, he responded "absolutely not. There is no evidence in the literature that early third molar removal is anything but a surgical exercise" (tr., pp. 63-64).

Dr. Offerman's testimony on cross examination relating to his objection to removal of LB's third molars by Dr. Nellen establishes his strongly held belief that Dr. Norwick ordered that they be removed rather than that she merely referred LB for an evaluation, as is established by the record. That position persisted even in the light of Dr. Offerman's concession that Dr. Nellen had a professional responsibility to determine that removal was in fact indicated and had in fact made that determination (tr., pp. 108-114). The record also establishes that removal of LB's wisdom teeth was not in fact part of Dr. Norwick's active orthodontic treatment, but rather that evaluation of the wisdom teeth came four months after insertion of the retainers, and at the request of LB's mother, who asked that they be evaluated because LB sensed that they were "pressing."

Which is not to say that Dr. Norwick disagreed with Dr. Nellen's evaluation. Asked whether she agreed with Dr. Nellen's opinion that the four wisdom teeth were indicated for removal, she responded:

> The positioning of them was such that they were interfering with the 12-year molar right in front of them and could have -- contribute to an adverse effect on the orthodontic correction. And it was evident that they were not going to erupt into any good position at all, that they would just continue to impact. And I concur with him (tr., pp. 333).

To conclude that Dr. Norwick's referral to Dr. Nellen, and the subsequent extraction of LB's third molars constituted a violation of §§ 447.07(3)(a) & (h) is to conclude that Dr. Nellen also demonstrated conduct falling below the minimum standards of the profession. Such a conclusion is certainly not supported by this record.

The last principal area of complainant's disagreement with Dr. Norwick's treatment of LB had to do with Dr. Norwick's having continued orthodontic treatment in the face of limited patient cooperation and resulting slow orthodontic progress. Dr. Offerman questioned whether patient

cooperation was indeed a factor inasmuch as there was no such problem in his treatment of that patient (at a time when, it should be noted, LB was a young woman rather than a child). Asked to assume that the degree of uncooperation was as noted in LB's patient record and in Dr. Norwick's letter to the department responding to the charges, he was then asked whether in his opinion a minimally competent dentist engaging in orthodontic treatment would have discontinued treatment in the circumstances described in Dr. Norwick's letter. He responded in the affirmative.

Dr. Thurow was less dogmatic on the point, conceding that the decision to terminate treatment at any given time would depend on the specific circumstances of the case, including whether there is limited cooperation or none at all, whether there is some progress or none at all, and what kind of promises are being made by the child and her parents in regard to future cooperation (tr., pp. 206-208).

Dr. Norwick's testimony was that she continued to treat LB in the face of poor cooperation because there was sufficient compliance to effect an improvement, and she therefore didn't want to give up on her.

> So I didn't want to abandon it because we did have progress, not what I desired, but we did have progress. She was not consistently noncompliant. If every single entry repeatedly had been noncompliance, then she would have been booted out. And we do have those individuals. But she wasn't consistent (tr., p. 318).

Asked whether he felt that Dr. Norwick should have abandoned treatment or modified treatment at various junctures, Dr. Rose agreed that so long as progress is being made, the decision to abandon a treatment modality or cease treatment altogether is a difficult one.

> . . . I think it depends on whether at the time of noncompliance or intermittent noncompliance, if there was progress being made, sometimes you simply stay the course even though the level of compliance is not as high as you'd like it, as long as the case continues to progress. . . (tr., p. 257).

Dr. Norwick would perhaps have done herself a favor by terminating treatment at the first sign of substantial noncompliance by LB. The fact that she did not in the circumstances shown here does not, however, demonstrate unprofessional conduct.

Finally, there were a couple of what might be termed side issues raised at hearing. The first of these was the suggestion that through the course of treatment, Dr. Norwick failed to consult appropriately with LB's parents. In her testimony at hearing, LB's mother indicated that there was a conversation between her and Dr. Norwick at the start of treatment, but that she "didn't remember" receiving any treatment plan or that any treatment alternatives were offered. She also didn't remember whether oral instructions on the use of the various appliances were provided, and she didn't recall Dr. Norwick ever counseling her about LB's failure to consistently wear the appliances or that there was any problem with LB's cooperation (tr., pp. 123-130). Any inference that the mother's failure to recall any of these things indicates that they did not occur was

resolved by her cross examination, where it became clear that she simply doesn't remember. The following is typical of that testimony:

> Q. Mrs.[B], Dr. Norwick's records indicate that a treatment plan was formulated on December 6, 1983, which is about ten years and one or two weeks ago, if I'm correct. And do you recall that meeting for the --
>
> A. The treatment plan?
>
> Q. -- where you discussed the treatment plan initially?
>
> A. No, I really do not.
>
> Q. Okay. If the records indicate that there was a discussion or at least a formulation of a plan to use headgear initially, do you recall a discussion about the use of headgear?
>
> A. I recall headgear being used, but I don't recall any discussion about it.
>
> Q. Well, the reason that I raise this with you is that Mr. Harris here just asked you about whether there was discussion about various alternative methods of treatment.
>
> A. Mm-hmm.
>
> Q. And what I want to know from you is, in December of 1983, can you tell us whether there was a discussion about alternative methods, or is simply that you don't recall?
>
> A. I'm sorry, I can't.
>
> Q. Okay. So, there may very well have been a discussion about alternate methods of treatment, but due to the passage of time, you honestly can't recall today. Would that be a fair statement?
>
> A. Yes. (tr., pp. 134-135)

The mother testified that she accompanied LB to each appointment and that on an unspecified number of occasions she was "called in" to the dental office following LB's treatment. To conclude that Dr. Norwick did not at that time consult with LB's mother relating to various issues that arose during the course of treatment stretches one's credulity.

Another side issue which arose related to Dr. Norwick's consultation with orthodontists during the course of treatment of LB. The complaint alleges that no such consultations took place, while complainant's closing alleges that those consults established at hearing as having occurred were not all noted in the patient record. It would appear that Dr. Norwick's conversations with orthodontists on the LB case were on a somewhat informal basis (tr., pp. 346-348), and failure to note those conversations in the record, while perhaps not conforming to the highest standards of

record-keeping, violates no specific provision of the board's code establishing standards of conduct.

II. Patient JA

Patient JA, then a boy of 13, was first seen by Dr. Norwick on June 19, 1989, for an orthodontic evaluation. That evaluation, based in part upon x-rays and models taken when JA was age 12.2, found that premature loss of the left upper baby canine had resulted in shifting of the upper midline to the left and shifting of the posterior molars forward. This in turn had resulted in the left upper canine being completely blocked out. No treatment was provided at that time.

JA's parents brought him back for reevaluation on September 7, 1990, and x-rays, models and photographs were obtained. Dr. Norwick's treatment plan noted that all four wisdom teeth were present and states "Best extract now!" Dr. Norwick's preferred treatment plan called for initial use of a removable Cetlin appliance with bite plate to distalize the left upper six and 12 year molars, followed by possible need to slenderize the molars and use of fixed appliances. Alternative plans called for extraction of upper and lower bicuspids and correction of the molars or, as a last resort, extracting the upper left first bicuspid only. JA's orthodontic treatment was to have started in December, 1990. However, an apparent dispute over insurance coverage occurred, and actual treatment was never initiated.

Dr. Offerman, who subsequently treated JA utilizing extraction therapy, testified at his deposition that the foregoing facts demonstrated incompetence by Dr. Norwick. That opinion was based on three premises. First, that JA's orthodontic condition was not susceptible to correction absent extractions; second, that Dr. Norwick's plan failed to address the midline shift; and third, that extraction of the wisdom teeth would contribute nothing to the treatment of JA's orthodontic condition. As to the efficacy of the treatment plan, Dr. Offerman's response to a question whether use of a removable Cetlin to distalize the upper left quadrant was a reasonable treatment modality included the following:

> Absolutely not, because it does not address the asymmetry. The problem is on the right side. She missed it completely. All the problems are on the right side. The reason the cuspid is blocked out is because the maxillary upper incisor teeth have drifted to the left, and there is no space for it. These teeth have also drifted forward. But the correction has got to be made on the right side. If you move these molar teeth on the left side -- which I doubt she can do because we've got a first and second molar. We're talking about the two of the biggest teeth in the mouth, both with three roots on them, so we've got six total roots to move back where there is no bone because we've just had wisdom teeth removed. There's nothing back there.
>
> If she would even have been able to do that, all it would do is exacerbate the problem because now we don't have any occlusion on the left side, and the upper midline is way over here [and the midline would continue to shift to the left] (Offerman deposition, pp. 91-92).

Complainant's other expert, Dr. Thurow, agreed that extraction orthodontics was necessary, but would have pursued extraction only of the first left upper bicuspid unless the progress of treatment dictated removal of bicuspids in the remaining three quadrants. Asked what follow-up treatment would be required after extracting the offending bicuspid, Dr. Thurow responded:

> It would require orthodontic appliances probably on all or most of the teeth to adjust the rest of the discrepancies. The teeth on the upper left side behind number 11 are all forward just about the width of the tooth I was speaking of removing, so it'd require only small adjustments between upper and lower there; some shifting of the anterior teeth to accommodate the -- the midline and the lower crowding. And that's where, as I said, it looks like a good prospect of doing it without additional extractions, . . .(tr., pp. 179-180).

While Dr. Thurow would thus agree with Dr. Offerman that extraction of tooth number 12 was necessary, he apparently disagrees with the assertion that the upper right first bicuspid and lower right second bicuspid should also have been removed, and disagrees as well that, as stated by Dr. Offerman, "all the problems are on the right side." Dr. Thurow, like Dr. Offerman, was of the opinion that extraction of the wisdom teeth would serve no orthodontic purpose, though Dr. Thurow's conclusion in that regard would seem to be premised on the assumption that the upper left first bicuspid would be removed:

> Q. . . . [D]o you have an opinion to a reasonable professional certainty as to whether removal of the wisdom teeth of [JA] was appropriate to treat his orthodontic condition.
>
> * * * *
>
> A. It would not be relevant if the bicuspid were removed as I described. There is a wisdom tooth behind the twelve year molar that this appliance is designed to move back. That would be a factor if that tooth were moved back a significant distance, which, as I said, would be doubtful of accomplishment. The other three wisdom teeth might need removal at some time, but there's no -- no orthodontic reason. (tr., pp. 182-183).

In terms of Dr. Norwick's treatment approach with patient JA, Dr. Rose testified that there is no way of knowing whether the patient could have been successfully treated without extracting bicuspids, because it was never attempted, but that his opinion was that "it would be difficult and possible" (tr., pp. 280-281). His further testimony on this aspect of the case included the following:

> Certainly one approach would be the extraction of four bicuspid teeth which would be very direct and much easier treatment approach. In terms of the biomechanics, which is the actual treatment itself, it would be much easier and straightforward.
>
> The other approach would be if, considering the compromised situation of the facial aesthetics of exrtraction orthodontics, that a doctor would be willing to begin a course of treatment in the direction of hopefully resolving the crowding in a non-extraction fashion. It could be started with the understanding that you're not certain whether this amount of crowding would be able to be alleviated and that a certain amount of time and effort would be invested, and that if the movements of the teeth that would be

> required to successfully complete the case on a non-extraction basis were not being accomplished, that you would abandon the non-extraction approach and at that time extract bicuspids and complete the case on an extraction basis (tr., p.283).

Addressing the question of removal of JA's third molars, Dr. Rose again disagreed with complainant's experts, testifying that based on his examination of JA's panoramic x-ray, "it would be improper to distalize six and 12-year molars in this case without extracting the upper wisdom teeth" (tr., p. 288).

The two dentists actually involved with treating JA at the time the decision to remove the wisdom teeth was made also quite obviously agreed that such removal was indicated. A November 1, 1990, report from Ronald H. Nellen, D.D.S., the oral surgeon who removed the third molars, states in part:

> [JA] presents to my office with his mother stating that he is currently asymptomatic and has no problems he can associate with his wisdom teeth. As you well know, the concern currently is that teeth numbers 1 and 16 may prevent desired orthodontic results due to crowding of the teeth. They now request my evaluation and treatment of all four wisdom teeth as needed.
>
> * * * *
>
> Panoramic radiographic evaluation reveals impacted teeth numbers 1, 16, 17 and 32, but no other significant pathology seen.
>
> Therefore, after reviewing the above, my impression was that all four wisdom teeth were indeed indicated for removal. And this is further discussed with the patient and his mother (Exh. #32; tr., pp. 118-119).

When asked whether she agreed with Dr. Nellen's decision, Dr. Norwick responded "I think that it was very wise" (tr., p. 120).

Complainant's contention that Dr. Norwick's proposed treatment failed to recognize the significance of the midline shift, as testified by Dr. Offerman, was also contradicted in the record. Both the evaluation done based on the November, 1988, records and that one done in September, 1990, make reference to a second phase of treatment utilizing straight wire fixed appliances. Dr. Norwick discussed this phase in her deposition testimony. Questioned regarding the 14.11 treatment plan, and the notation "if coop good, SW," Dr. Norwick was asked by Mr. Harris what she had in mind:

> Well, once we achieved enough room to accommodate the canine, we would then continue on with the regular fixed appliances to align all of the teeth, take care of the crowding in the lower arch, which is minor, get the midline on, which is two tiny millimeters off, and finalize the occlusion (Norwick dep., p. 79).

It is interesting to note that with the exception of the manner in which space for the canine was to be created, Dr. Norwick's treatment plan was strikingly similar to that suggested by Dr. Thurow. Again, when asked what treatment should follow extraction of the bicuspid, Dr. Thurow testified:

> It would require orthodontic appliances probably on all or most of the teeth to adjust the rest of the discrepancies. The teeth on the upper left side behind number 11 are all forward just about the width of the tooth I was speaking of removing, so it'd require only small adjustments between upper and lower there; some shifting of the anterior teeth to accommodate the midline and the lower crowding. And that's where, as I said, it looks like a good prospect of doing it without additional extractions, . . .(tr., pp. 179-180).

Finally, Dr. Thurow was critical of the design of the Cetlin appliance designed to distalize the left upper molars, testifying that the device would have done little more than retain those teeth in their asymmetrical positions (tr., p.181). It would appear that Dr. Thurow's testimony that the appliance would not do what it was designed to do stands alone. The point, however, is that the appliance was never utilized, and there is nothing in this record to establish that had it been, and had it in fact been improperly designed or constructed, Dr. Norwick would not have observed that fact.

In the last analysis, even respondent's expert witness was compelled to testify that Dr. Norwick's non-extraction approach to Patient JA's orthodontic problems presented difficulties and could well not have succeeded. We don't know that, however, because with the exception of removing the wisdom teeth, as recommended by the dental surgeon, treatment never went forward. And that, of course, is the telling point. There's a certain amount of speculation inherent in any attempt to draw conclusions as to whether Dr. Norwick's orthodontic treatment of JA would have fallen below the minimum standards of the profession without that treatment having been provided. The record indicates that JA subsequently had an apparently satisfactory orthodontic result utilizing extraction therapy, and there is no question based on the evidence in this case that such an approach constituted a viable treatment alternative. What was not proven by a preponderance of the evidence is that it was the <u>only</u> viable treatment approach.

III. Conclusion

It seems apparent from this record that Dr. Norwick's orthodontic treatment of patient LB led to what may be termed a suboptimal result, and that her recommended orthodontic treatment of patient JA, if actually undertaken, may also have resulted in a less than optimal outcome. What we are concerned with here, however, is not whether optimal dental care was provided, but rather whether the care provided constituted a substantial danger to the health, welfare or safety of these patients, or constituted practicing while unable to do so with reasonable skill and safety to these patients, or constituted practicing in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which harmed or could have harmed these patients. It is not necessary to conclude that complainant's experts were entirely wrong in their opinions, or that

respondent's expert was entirely right in his, to decide that Dr. Norwick's care did not cross the ill-defined but important line between minimally acceptable care and care which harmed or could have harmed her patients. Accordingly, the proceedings herein must be dismissed.

Dated this 6th day of May, 1994.

Respectfully submitted,

Wayne R. Austin
Administrative Law Judge

WRA:030442

NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review, The Times Allowed For Each, And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

THE STATE OF WISCONSIN DENTISTRY EXAMINING BOARD

1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708.

The Date of Mailing this Decision is:

JULY 11, 1994

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)