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STATE OF WISCONSIN

BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST:

JOHN N. BONNELL, D.D.S.,	FINAL DECISION AND ORDER
RESPONDENT	LS0010101DEN

The parties to this proceeding for purposes of sec. 227.53, Stats., are:

John N. Bonnell, D.D.S.

225 N. Richmond St.

Appleton, WI 54911

Wisconsin Dentistry Examining Board

1400 E. Washington Ave.

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

1400 E. Washington Ave.

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Madison, WI 53708-8935

The Wisconsin Dentistry Examining Board received a Stipulation submitted by the parties to the above-captioned matter. The Stipulation, a copy of which is attached hereto, was executed by John N. Bonnell, D.D.S., personally, and by his attorney, W. Patrick Sullivan, and by Gilbert C. Lubcke, attorney for the Department of Regulation and Licensing, Division of Enforcement. Based upon the Stipulation of the parties, the Wisconsin Dentistry Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. John N. Bonnell, D.D.S., 225 N. Richmond Street, Appleton, Wisconsin, 54911, was born on 12/29/52 and has been licensed and registered to practice dentistry in the state of Wisconsin since 7/14/77, license #5001888.

2. Dr. Bonnell is engaged in the practice of general dentistry.

3. Dr. Bonnell, by a Final Decision And Order of the Dentistry Examining Board dated 11/6/91, was previously disciplined for violations of secs. 447.07(3)(a), 447.07(3)(f), and 447.07(3)(g), Stats. and Wis. Admin. Code sec. DE 5.02(5). The discipline was imposed for providing a removable maxillary partial denture for a patient with

gingivitis without determining if there was periodontal involvement and bone loss, and for failing to include a medical history, dental history, treatment plan, exam sheet and full mouth x-rays in his records for a patient who presented with gingivitis and who needed extensive work, including a partial and root canal therapy. The Board ordered that Bonnell's license be suspended for 15 days, that he participate in and successfully complete a program in dental recordkeeping at Marquette University School of Dentistry and that he participate in and successfully complete 120 hours of continuing dental education credit in the area of diagnosis, treatment and periodontal assessment at the Marquette University School of Dentistry.

COUNT I

4. D.R., the patient herein, received dental care from Dr. Bonnell from 11/15/83 through 4/5/94.

5. Dr. Bonnell placed porcelain crowns on tooth #2 on 8/8/89, on tooth #3 on 6/20/89 and on tooth #15 on 8/10/89. These crowns did not fit properly at the time that they were placed and had large overhangs.

6. Dr. Bonnell did not identify the poorly fitting crowns, did not advise the patient of the poorly fitting crowns, did not develop a treatment plan to correct the poorly fitting crowns and did not take any action to correct the poorly fitting crowns at any time while the patient was under his care.

7. Dr. Bonnell's conduct substantially departed from the standard of care in that he:

a. Placed crowns on teeth #2, 3 and 15 that did not fit properly and had large overhangs at the time that they were placed.

b. Failed to identify the poorly fitting crowns with large overhangs and advise the patient of the situation.

c. Failed to develop a treatment plan and take action to correct the poorly fitting crowns with large overhangs by removing them and replacing them with crowns that fit properly.

8. Dr. Bonnell's conduct in placing crowns on teeth #2, 3 and 15 that did not fit properly and his failure to identify the poorly fitting crowns and take appropriate action to correct the poorly fitting crowns created the following unacceptable risks of harm for the patient:

a. Leakage around the poorly fitting crowns resulting in the development of dental caries.

b. Development and aggravation of periodontal disease as a result of the difficulty of maintaining good oral hygiene in areas where the crowns have large overhangs.

COUNT V

9. R.C., the patient herein, received dental care from Dr. Bonnell from 6/2/93 through 3/15/95.

10. The patient was allergic to penicillin and reported this to Dr. Bonnell at the time of the patient's office visit on 6/2/93. Dr. Bonnell recorded this information in the "Medical Alert" section of the patient's dental records.

11. In the fall of 1994, the patient lost a filling in tooth #12 and, on or about 3/12/95, a portion of tooth #12 broke off. On 3/15/95, the patient presented at Dr. Bonnell's office complaining of pain associated with tooth #12. The patient requested that tooth #12 be extracted.

12. At the appointment on 3/15/95, Dr. Bonnell did not obtain and record an adequate medical history relating to tooth #12, did not perform and record the results of an adequate clinical examination of tooth #12 and did not obtain a current x-ray of tooth #12. Dr. Bonnell had a periapical x-ray in the patient's records from 6/2/93 that included a portion of tooth #12.

13. Dr. Bonnell did not develop viable alternative treatment options for tooth #12 and did not advise the patient of the viable alternative treatment options for tooth #12. Dr. Bonnell recommended extraction of tooth #12, but he did not advise the patient of the consequences of the extraction, including additional dental procedures that may be required if the tooth was extracted.

14. On 3/15/95, Dr. Bonnell attempted a simple extraction of tooth #12. Dr. Bonnell concluded that the extraction was performed without any problems. Dr. Bonnell did not conduct an adequate examination of the tooth after he extracted it and did not conduct an adequate examination of the extraction site for retained portions of the tooth or bone fragments.

15. In fact, the patient was discharged from Dr. Bonnell's office on 3/15/95 with a portion of tooth #12, included

one complete root, retained in the socket.

16. Dr. Bonnell discharged the patient from his office on 3/15/95 with a prescription for 24 Pen VK.

17. Pen VK is a form of penicillin.

18. The patient took the prescription for Pen VK to the Walgreens Pharmacy in Waupaca, Wisconsin to have it filled. The pharmacist on duty was aware of the patient's penicillin allergy and advised the patient that Pen VK was a form of penicillin. The pharmacist, with the patient's consent, contacted Dr. Bonnell, advised him that he had prescribed an antibiotic to which the patient was allergic and recommended to Dr. Bonnell that he substitute a prescription for 24 Erythromycin 500 mg. Dr. Bonnell accepted the recommendation. The pharmacist changed the prescription to Erythromycin and filled it for the patient.

19. The patient developed increased pain and swelling in the week following 3/15/95.

20. On 3/20/95, the patient made an appointment with and was examined by Gregory P. Harvey, D.D.S. Dr. Harvey's examination disclosed the retained portion of the tooth, including one root, at the location of tooth #12.

21. On 3/21/95, Dr. Harvey performed a simple surgical extraction of the remaining portions of tooth #12.

22. Dr. Bonnell's conduct substantially departed from the standard of care in that he:

a. Discharged the patient from his office on 3/15/95 with a prescription for Pen VK, a form of penicillin, when he knew or should have known that the patient was allergic to penicillin.

b. Failed on 3/15/95 to obtain and record a minimally competent dental history relating to tooth #12, failed to conduct and record the results of a minimally competent clinical examination of tooth #12 and failed to obtain a current x-ray of tooth #12, all of which were necessary to making a diagnosis and formulating viable alternative treatment options.

c. Failed on 3/15/95 to advise the patient of viable alternative treatment options for tooth #12.

d. Failed on 3/15/95 to advise the patient of the consequences of the treatment options, including additional dental procedures that may be necessary as a consequence of the treatment option elected by the patient to address the acute problem.

e. Failed on 3/15/95 to conduct a minimally competent examination of the portion of tooth #12 he extracted to determine if any portion of the tooth had been retained.

f. Failed on 3/15/95 to conduct a minimally competent clinical examination of the extraction site to determine if any portion of the tooth had been retained or if any bone fragments were present.

g. Failed on 3/15/95 to extract tooth #12 in its entirety.

23. Dr. Bonnell's conduct created the following unacceptable risks of harm for the patient:

a. The patient would ingest the Pen VK and experience an allergic reaction.

b. The patient, not having been advised of the viable treatment options for tooth #12 and the consequences of the treatment options, may agree to a treatment that, although addressing the acute problem, may not serve the interests of his long term dental health and welfare and that may require additional dental procedures that may have been unnecessary if a different treatment option had been chosen.

c. The retained portion of tooth #12 will cause continuing inflammation and pain, impair healing and promote infection at the extraction site.

COUNT VII

24. E.I., the patient herein, was born on 2/2/79 and received dental care from the Dr. Bonnell from 4/29/92 through 7/24/96.

25. Dr. Bonnell conducted general dental examinations for the purpose of detecting dental caries on 4/29/92, 5/4/94 and 5/3/95. As part of the general dental examination on 5/3/95, Dr. Bonnell took 4 periapical x-rays that included images of teeth #2, 3, 4, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30 and 31. He did not take any additional x-rays on 5/3/95 and did not obtain any x-rays on 4/29/92 or 5/4/94.

26. Dr. Bonnell did not diagnose or treat any dental caries at the time of his general dental examination of the patient on 5/3/95.

27. On 8/19/96, the patient went to James Duwell, D.D.S. for a general dental examination. Dr. Duwell took a full mouth set of x-rays. The x-rays disclosed deep dental caries in teeth #2, 3, 12 and 14.

28. The dental caries in teeth #2, 3, 12 and 14 were present and should have been detected by a competent dental examination on 5/3/95.

29. The dental caries in teeth #2, 3, 12 and 14 should have been treated by excavation and restoration on 5/3/95 or promptly thereafter.

30. The patient required root canal therapy on tooth #2 on 1/22/97, on tooth #3 on 1/22/97, on tooth #12 on 1/6/97 and 1/13/97, and on tooth #14 on 10/21/96.

31. Dr. Bonnell's conduct substantially departed from the standard of care in that he:

a. Failed to conduct minimally competent general dental examinations on 4/29/92, 5/4/94 and 5/3/95 by failing to obtain a minimum of 4 current bitewing x-rays at each of these general dental examinations for the purpose of detecting dental caries.

b. Failed on 5/3/95 to diagnose and promptly treat the dental caries in teeth #2, 3, 12 and 14.

32. Dr. Bonnell's conduct created the following unacceptable risks of harm for the patient:

a. The dental caries that may have been present but not diagnosed at the times of the general dental examinations on 4/9/92, 5/4/94 and 5/3/95, and the dental caries in teeth #2, 3, 12 and 14 that were present and diagnosable on 5/3/95, if left undiagnosed and untreated will continue to progress, require more extensive excavation and restoration, involve the pulp of the teeth and result in increased pain and infection and the need for more aggressive dental treatment, including root canal therapy or extraction of the teeth.

COUNT IX

33. P.L., the patient herein, received intermittent dental care from Dr. Bonnell from 10/29/96 through 2/23/98.

34. The patient's initial appointment with Dr. Bonnell was on 10/29/96. Dr. Bonnell performed a general dental examination on that date for the purpose of detecting dental caries. As a part of this general dental examination, Dr. Bonnell took 4 periapical x-rays for caries detection. Dr. Bonnell treated teeth #4 and 5, but he did not diagnose or treat dental caries in any other teeth on 10/29/96.

35. The periapical x-rays that Dr. Bonnell took on 10/29/96 showed advanced dental caries in teeth #2, 3, 18 and 20 and moderate dental caries in tooth #21.

36. On 10/2/97, the patient was examined by William Barton, D.D.S. He referred the patient to David Gamm, D.D.S., an endodontist, for an evaluation of teeth #20, 21 and 29.

37. On 10/3/97, David Gamm, D.D.S., examined the patient and recommended root canal therapy for teeth #20 and 29. Dr. Gamm also noted deep dental caries in tooth #18. On 10/3/97, Dr. Gamm completed root canal therapy on tooth #20. Dr. Gamm sealed the apex of tooth #20 with gutta percha and created a post space of 16.0 mm with a #80 size. He closed tooth #20 with a temporary filling after placing a cotton plug over the opening to the post space to prevent filling material from entering the post space. Dr. Gamm recommended to the patient that she consult with her general practice dentist to complete the restoration of tooth #20.

38. On 11/25/97, the patient transferred her general dental care to John Christian, D.D.S. On 12/30/97, Dr. Christian diagnosed a fracture in tooth #4 and recommended that the tooth be extracted.

39. On 2/10/98, the patient went to Dr. Bonnell to have tooth #4 extracted. Dr. Bonnell, in addition to extracting tooth #4 on 2/10/98, discussed with the patient whether he could perform root canal therapy on teeth #18 and 29.

40. On 2/23/98, the patient returned to Dr. Bonnell's office. Dr. Bonnell opened tooth #20, the tooth on which root canal therapy had previously been completed, cleaned out the tooth, removed the cotton plug that protected the post space and then placed a temporary sedative filling in the tooth. Dr. Bonnell did not take any x-rays of tooth #20 before opening the tooth.

41. On 2/24/98, the patient returned to Dr. Gamm's office. Dr. Gamm took another x-ray of tooth #20. The x-ray

indicated that the access to tooth #20 originally placed by Dr. Gamm had been altered but the root canal and post space had not been altered.

42. On 3/17/98, Dr. Gamm completed root canal therapy on tooth #29.

43. On 4/27/98, Dr. Christian extracted tooth #18.

44. Dr. Bonnell engaged in conduct that indicated a lack of knowledge of and an inability to apply the principles and skills of dentistry in that he:

a. Failed on 10/29/96 to conduct a minimally competent general dental examination for detection of dental caries by failing to obtain a minimum of 4 bitewing x-rays for caries detection.

b. Failed on 10/29/96 to diagnose and promptly treat the dental caries in teeth #2, 3, 18, 20 and 21.

c. Failed on 2/23/98 before opening tooth #20 to obtain a periapical x-ray of the tooth to determine the status of the root canal therapy and to assist with the diagnosis of any condition that could cause the symptoms that he believed the patient presented with.

d. Opened tooth #20 on 2/23/98 and performed procedures on tooth #20 without any medical/dental justification.

45. John N. Bonnell has voluntarily agreed to surrender his license to practice dentistry in the State of Wisconsin, effective 2/28/01. He has agreed that he will not make application for or attempt reinstatement of his license to practice dentistry in the State of Wisconsin at any time in the future. He has agreed to limit his practice of dentistry in the State of Wisconsin from the date of this Final Decision And Order until 2/28/01 to completing dental treatment plans in progress for patients under his care on the date of this Final Decision And Order, to notifying his patients of the termination of his practice, to making provisions for the orderly transfer of his patients to other dentists in order to maintain the continuity of their dental care and to making arrangements for the transfer of patient records either to the patient or to the patients' new dentists.

CONCLUSIONS OF LAW

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

2. The Wisconsin Dentistry Examining Board has the authority to resolve this disciplinary proceeding by stipulation without an evidentiary hearing pursuant to sec. 227.44(5), Stats.

3. Dr. Bonnell's conduct as described in paragraphs 4 through 8 of the Findings of Fact was unprofessional conduct contrary to sec. 447.07(3)(a), Stats. and Wis. Admin. Code sec. DE 5.02(5) in that he practiced in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which could have harmed the patient.

4. Dr. Bonnell's conduct as described in paragraphs 9 through 23 of the Findings of Fact was unprofessional conduct contrary to sec. 447.07(3)(a), Stats. and Wis. Admin. Code sec. DE 5.02(5) in that he practiced in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which could have harmed a patient.

5. Dr. Bonnell's conduct as described in paragraphs 24 through 32 of the Findings of Fact was unprofessional conduct contrary to sec. 447.07(3)(a), Stats. and Wis. Admin. Code sec. DE 5.02(5) in that he practiced in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which could have harmed the patient.

6. Dr. Bonnell's conduct as described in paragraphs 33 through 44 of the Findings of Fact was contrary to sec. 447.07(3)(h), Stats. in that he engaged in conduct that indicated a lack of knowledge of and an inability to apply the principles and skills of dentistry.

7. The Wisconsin Dentistry Examining Board has the authority pursuant to sec. 440.22, Stats., to assess the costs of this proceeding against Dr. Bonnell.

ORDER

NOW, THEREFORE, IT IS ORDERED that the Stipulation of the parties is approved.

IT IS FURTHER ORDERED that John N. Bonnell, D.D.S. surrender his license to practice dentistry in the State of Wisconsin effective 2/28/01.

IT IS FURTHER ORDERED that John N. Bonnell, D.D.S. will not make application for or attempt reinstatement of his license to practice dentistry in the State of Wisconsin at any time in the future.

IT IS FURTHER ORDERED that John N. Bonnell, D.D.S. will limit his practice of dentistry in the State of Wisconsin from the date of this Final Decision And Order until 2/28/01 to completing dental treatment plans in progress for patients under his care on the date of this Final Decision And Order, to notifying his patients of the termination of his practice, to making provisions for the orderly transfer of his patients to other dentists in order to maintain the continuity of their dental care and to making arrangements for the transfer of patient records either to the patients or to the patients' new dentists.

IT IS FURTHER ORDERED that John N. Bonnell, D.D.S. will not practice or attempt to practice dentistry in the State of Wisconsin when he is not currently licensed.

IT IS FURTHER ORDERED that John N. Bonnell, D.D.S., will pay the costs of this proceeding in the amount of $900.00 to the Department of Regulation and Licensing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin, 53708-8935 within 60 days of the date of this Final Decision And Order.

IT IS FURTHER ORDERED that Counts II, III, IV, VI, VIII, X and XI of the Complaint are dismissed.

The rights of a party aggrieved by this Final Decision And Order to petition the Wisconsin Dentistry Examining Board for rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal Information".

Dated at Madison, Wisconsin, this 3rd day of January, 2001.

WISCONSIN DENTISTRY EXAMINING BOARD

Bruce Barrette

Member, Wisconsin Dentistry Examining Board