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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
ALLEN RICHARD WELSH, DDS, RESPONDENT.	:	LS0501031DEN

Division of Enforcement Case No. 04DEN006

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 this12th day of July, 2006.

Keith D. Clemence
Member of the Board
Dentistry Examining Board

STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**PROPOSED FINAL DECISION AND ORDER**
ALLEN RICHARD WELSH, D.D.S., RESPONDENT.	:	LS-0501031-DEN

Division of Enforcement Case File No. 04 DEN 6

PARTIES

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Allen Richard Welsh, DDS
7925 S. Wynbrook Court
Oak Creek, Wisconsin, 53154-3069

Wisconsin Dentistry Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

This proceeding was commenced by the filing of a Notice of Hearing and Complaint on December 22, 2004. An Amended Complaint was filed on January 19, 2005. The Respondent's Answer to the Amended Complaint was filed on February 4, 2005. A hearing in the above-captioned matter was held on November 1, 2, and 29, 2005. Attorney Arthur Thexton appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney W. Patrick Sullivan appeared on behalf of the Respondent, Allen Richard Welsh, DDS.

Based upon the record herein, the Administrative Law Judge recommends that the Dentistry Examining Board adopt as its final decision and order in the matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Allen Richard Welsh ("Respondent") date of birth 04/11/59, is and was at all times relevant to the facts set forth herein a dentist licensed in the State of Wisconsin pursuant to license #15-3569. This license was first granted October 7, 1985.

2. The Respondent's last reported address on file with the Department of Regulation and Licensing is 7925 S. Wynbrook Court, Oak Creek WI 53154-3069.

3. At all times relevant to the allegations stated in the Complaint filed in this matter, the Respondent was employed as a general dentist for the Department of Corrections ("DOC") in Green Bay, Wisconsin.

4. The Respondent began his employment with DOC on September 4, 2002, as a Limited Term Employee (LTE).

5. On October 7, 2002, the Respondent began working on a full-time basis for DOC. Respondent was promoted to the position of Dental Supervisor on August 22, 2003 and remained in that position until October 29, 2003, when he was placed on administrative leave due to concerns about the quality of his dental care.

6. On December 18, 2003, the Respondent was terminated from his position as a dentist for DOC.

Count I: 04 DEN 6

7. Prior to the termination of his employment with DOC, an investigation and review of the Respondent's dental care was conducted by Dr. Ripani, the DOC Dental Director, who is in charge of all the dental units in the state prison system.

8. On April 2, 2003, the Respondent purported to remove decay and place fillings on teeth #6, #7, #8, #9, #10, #11, #12, #14, and #16 for inmate Kenneth R. On April 10, 2003, the Respondent redid the filling in tooth #8 and adjusted the occlusion on the teeth which had been previously filled, except for tooth #16.

9. On September 9, 2003, in response to Kenneth R.'s complaints of continuing pain, the patient was reexamined by another DOC dentist.

10. Teeth #8 and #9 of Kenneth R. were poorly sealed and unremoved decay was underneath the fillings placed by the Respondent. Root canals were required and so much decay occurred on tooth #9 that a post and core were required.

11. On July 2, 2003, the Respondent purported to remove the decay and place fillings on teeth #2, #3, #6, #8, #9, #11, and #21 for inmate Larry T.

12. The Respondent failed to remove the excess flash or overhang on the teeth which he filled for Larry T., which resulted in a food trap area that increases carious or periodontal infection.

13. On July 14, 2003, another DOC dentist examined Larry T., who was complaining of pain in teeth #8 and #11. Upon examination, it was determined that the teeth #8 and #11 had decay underneath the fillings. The filling in Larry T.'s tooth #21 was replaced and the fillings in teeth #9 and #11 were polished.

14. On July 17, 2003, another DOC dentist extracted Larry T.'s tooth #21.

15. On July 29, 2003, another DOC dentist extracted Larry T.'s teeth #7 and #10.

16. On July 3, 2003, the Respondent performed root canal therapy on tooth #4 of inmate Vincent H.

17. In performing the root canal on Vincent H., the Respondent placed the gutta-percha filling beyond the apex by several millimeters which caused it to extend into the maxillary sinus area.

18. The Respondent recognized that he had gone beyond the apex and wrote in the patient's dental record that either the cone broke through the apex or he was overextended 4.5 to 5 millimeters, but he did nothing further to remedy the problem.

19. Six months later, on January 9, 2004, a subsequent treating dentist had to extract tooth #4 of Vincent H. Upon extraction, a lesion was found at the apex or in the sinus with evidence of possible forced instrumentation.

20. On August 29, 2003, the Respondent placed a stainless steel crown on tooth #12 for inmate Larry P.

21. The stainless steel crown for Larry P.'s tooth #12 was not properly adapted or "crimped" to the margin by the Respondent, which left the tooth vulnerable to recurrent caries and periodontal problems.

22. On October 27, 2003, another dentist examined Larry P., who had presented with pain and bleeding around the stainless steel crown placed by the Respondent. The patient was found to have chronically-inflamed interproximal gingival tissues around his stainless steel crowns, including tooth #12.

23. Proper dental tools (crown crimpers, pliers and dental scissors) for use in placing stainless steel crowns were available at the DOC dental clinic, but the Respondent failed to use them.

24. The Respondent recorded in Larry P.'s dental chart that he prescribed amoxicillin as a pre-medication for the patient, but he had actually prescribed clindamycin because the patient was allergic to antibiotics in the penicillin family.

25. On July 15, 2003, the Respondent purported to remove decay and place fillings in Michael R.'s teeth #18 and #20 and approximately one week later, another dentist had to smooth a broken cusp on one of these teeth.

26. While in the clinic doing his routine janitorial work, Michael R. complained to the Respondent of continued dental discomfort and temperature sensitivity in the teeth on the lower right side.

27. On October 9, 2003, in response to Michael R.'s complaint, the Respondent placed desensitizer on teeth #28, #29, and #31 without examining or x-raying these teeth or reviewing the patient's dental record. The following day, the patient reported that the gel caused the teeth to hurt more than before.

28. On October 16, 2003, the Respondent placed flowable buccal resins on Michael R.'s teeth, again to reduce pain, without taking any action to determine the cause of the patient's pain and discomfort.

29. On October 22, 2003, Michael R. reported continuing pain, and the Respondent prescribed ibuprofen, but again failed to x-ray the teeth, perform a dental examination, or review the patient's previous x-rays in his dental chart.

30. On October 31, 2003, Michael R. was treated by another DOC dentist who performed a thorough examination and took radiographs. The dental films showed caries in tooth #31 and severe bone loss in the immediate area from periodontal disease, which the Respondent had failed to detect and treat.

31. The previous x-rays and treatment notes contained in the dental records for Michael R. also revealed caries in tooth #31, advanced periodontal disease and periodontal bone loss.

32. The Respondent had ready access to Michael R.'s dental chart which showed the condition of the patient's teeth and cause of his pain.

33. On October 15, 2003, the Respondent surgically extracted tooth #14 for inmate Lucas E. During the procedure, the Respondent gouged the root of tooth #13 with the dental bur on multiple occasions and removed cortical bone.

34. The dental record for inmate Lucas E. did not contain any reference by the Respondent of the damage to tooth #13 or the possible resulting complications from this damage.

35. Tooth #13, a healthy tooth, later had to be extracted and a separate procedure performed to graft bone into the defect as a result of the Respondent's actions.

Count II: 01 Den 36/116

36. Since 1991, the Respondent has suffered from chronic back pain and has sought relief through various treatment modalities. For a period extending from 1998, through October, 2000, Respondent obtained hydrocodone products and other controlled substances for his personal use for pain relief from various sources.

37. On the following dates, the Respondent obtained the following products, all of which are controlled substances, from a licensed drug distributor.

Date	Drug ordered	Quantity
10/7/1999	hydrocodone w/APAP 5/500mg	1,000
10/11/1999	hydrocodone w/APAP 5/500mg hydrocodone w/APAP 10/650mg	1,000 300
1/19/2000	hydrocodone w/APAP 5/500mg hydrocodone w/codeine 60mg	500 200
2/24/2000	hydrocodone w/APAP 5/500mg	500
3/22/2000	hydrocodone w/APAP 5/500mg hydrocodone w/codeine 60mg	1,000 200

38. The Respondent failed to keep any records of receipt for these products or biennial inventories of the products obtained from the licensed drug distributor.

39. The Respondent failed to keep adequate records of the dispensing of these products or to keep any records of the disposing of these products other than by dispensing.

40. The Respondent consumed some of these controlled substances referenced in paragraph #36 without a legitimate prescription order from another authorized prescriber.

41. On 18 occasions between April 27, 1998 and October 10, 2000, the Respondent obtained prescription orders for 30 and 90 dosage units of hydrocodone products or Soma® compound with codeine (all of which are controlled substances) from three dentist acquaintances other than in the course of legitimate dental practice.

42. Respondent consumed these controlled substances obtained from other dentists knowing that he had obtained the orders other than in the legitimate course of dental practice.

43. On 16 occasions between May 31, 1996 and December 31, 2000, the Respondent also solicited three dentist acquaintances to issue prescription orders for 30 and 90 dosage units of hydrocodone products ostensibly for his spouse, for non-dental conditions. These orders, all of which are for controlled substances, were prepared by the Respondent and presented to the dentist acquaintances, who signed them.

44. Respondent filled the prescriptions which were purportedly for his wife and consumed all or part of each prescription himself.

45. Between September 24, 1999 and January 30, 2001, the Respondent telephoned 12 prescription orders to pharmacies for 30 dosage units of hydrocodone products for his wife under the pseudonym "Susan Wright" ostensibly to treat his wife's migraine headaches. The Respondent's wife had these prescription orders filled, and the Respondent took a substantial portion of his wife's prescription for his own personal use.

46. Between October 17, 2000 and January 4, 2001, the Respondent wrote three prescription orders for 30 dosage units of hydrocodone products for his sister-in-law or his mother-in-law. The Respondent's sister-in-law has endometriosis, a non-dental condition, and all prescriptions were written to treat that condition. The Respondent's sister-in-law and mother-in-law occasionally gave him hydrocodone tablets, which he consumed without a legitimate prescription order from an authorized prescriber.

47. Between February 25 , 1997 and January 28, 2001, the Respondent issued 34 prescription orders for 12 and 30 dosage units of hydrocodone or other controlled substance products to a dentist associate, Dr. Reed, for pain not documented to relate to a dental condition. The Respondent has no patient health care record for Dr. Reed.

48. On January 31, 2001, at the request of the DEA, the Respondent surrendered his DEA registration for cause pursuant to 21 CFR §1301.76(2). The Respondent's DEA registration has since been reinstated, subject to a *Letter of Agreement.*

49. The Respondent has been under the care of a physician specializing in pain management for at least three years, and

has not engaged in the type of conduct described in Count II since obtaining proper care.

CONCLUSIONS OF LAW

A. The conduct described in Count I, above, constitutes unprofessional conduct as defined in § DE 5.02(1) and (5), Wis. Admin. Code, and negligence in practice as defined in Wis. Stats. § 447.07(3)(h).

B. The conduct described in Count II, above, constitutes a violation of § 447.07(3)(a), (f), and (h), Wis. Stats., § 961.38(5), Wis. Stats., § DE 5.02(1), (3), (5), (6), (15), (16), and (2), Wis. Admin. Code, and 21 CFR §§ 1304.04(f) and (g), 1304.11(a), (b), and (c), and 1304.21 (a) and constitutes unprofessional conduct within the meaning of the administrative code and statutes.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (##3569) of ALLEN RICHARD WELSH, DDS, to practice as dentist in the state of Wisconsin, be, and hereby is REVOKED.

IT IS FURTHER ORDERED that pursuant to Wis. Stats. § 440.22, the full costs of this proceeding shall be assessed against the Respondent, and shall be payable to the Department of Regulation and Licensing.

IT IS FURTHER ORDERED that the Respondent shall surrender his DEA registration within five (5) days of the acceptance of this decision.

OPINION

The Division of Enforcement alleges in its Complaint and Amended Complaint that by engaging in the conduct described therein, the Respondent violated § DE 5.02(1) and (5), Wis. Admin. Code, and Wis. Stats. § 447.07(3)(h).

It is also alleged that the conduct described above constitutes a violation of § 447.07(3)(a), (f), and (h), Wis. Stats., § 961.38(5), Wis. Stats., § DE 5.02(1), (3), (5), (6), (15), (16), and (2), Wis. Admin. Code, and 21 CFR §§ 1304.04(f) and (g), 1304.11(a), (b), (c), and 1304.21 (a). The preponderance of the evidence presented at the hearing establishes that these violations occurred as alleged.

I. APPLICABLE LAW

Chapter DE 5, Standards of Practice, Wis. Admin. Code.DE 5.02, Unprofessional conduct. Unprofessional conduct by a dentist or dental hygienist includes:

(1) Engaging in any practice which constitutes a substantial danger to the health, welfare or safety of a patient or the public
(2) Practicing or attempting to practice when unable to do so with reasonable skill and safety to patients.
(3) Practicing or attempting to practice beyond the scope of any license or certificate.
(5) Practicing in a manner which substantially departs from the standard of care ordinarily exercised by a dentist or dental hygienist which harms or could have harmed a patient.
(6) Administering, dispensing, prescribing, supplying or obtaining controlled substances as defined in s. 961.01(4), Stats. other than in the course of legitimate practice, or as otherwise prohibited by law.
(15) Violating any law or being convicted of any crime the circumstances of which substantially relate to the practice of a dentist or a dental hygienist.
(16) Violating any provision of ch. 447, Stats., or any valid rule of the Board.

447.07, Wis. Stats., Disciplinary Proceedings

(3)(a) Engaged in unprofessional conduct.
(3)(f) Violated this chapter or any federal or state statute or rule which relates to the practice of dentistry or dental

hygiene.
(3)(h) Engaged in conduct that indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry or dental hygiene.

961.38(5), Wis. Stats. Uniform Controlled Substances Act.

No practitioner shall prescribe, orally, electronically or in writing, or take without a prescription a controlled substanc included in schedule I, II, III or IV for the practitioner's own personal use.

21 CFR §§ 1304.04, Maintenance of records and inventories

(f) Each registered manufacturer, distributor, importer, exporter, narcotic treatment program and compounder for narcoti treatment program shall maintain inventories and records of controlled substances as follows: (1) Inventories and record of controlled substances listed in Schedules I and II shall be maintained separately from all of the records of the registrant and

(2) Inventories and records of controlled substances listed in Schedules III, IV and V shall be maintained either separatel from all other records of the registrant or in such form that the information required is readily retrievable from the ordinar business records of the registrant.

(g) Each registered individual practitioner required to keep records and institutional practitioner shall maintain inventorie and records of controlled substances in the manner prescribed in paragraph (f) of this section.

21 CFR 1304.11, Inventory requirements

(a) General requirements. Each inventory shall contain a complete and accurate record of all controlled substances o hand on the date the inventory is taken, and shall be maintained in written, typewritten, or printed form at the registere location. An inventory taken by use of an oral recording device must be promptly transcribed. Controlled substance shall be deemed to be "on hand" if they are in the possession of or under the control of the registrant, including substance returned by a customer, ordered by a customer but not yet invoiced, stored in a warehouse on behalf of the registrant, an substances in the possession of employees of the registrant and intended for distribution as complimentary samples. A separate inventory shall be provided in paragraph (e)(4) of this section. In the event controlled substances in th possession or control of the registrant are stored at a location for which he/she is not registered, the substances shall b included in the inventory of the registered location to which they are subject to control or to which the person possessin the substances is responsible. The inventory may be taken either as of opening of business or as of the close of busines on the inventory date and it shall be indicated on the inventory.

(b) Initial inventory date. Every person required to keep records shall take an inventory of all stocks of controlle substances on hand on the date he/she first engages in the manufacture, distribution, or dispensing of controlle substances, in accordance with paragraph (e) of this section as applicable. In the event a person commences busines with no controlled substances on hand, he/she shall record this fact as the initial inventory.

(c) Biennial inventory date. After the initial inventory is taken, the registrant shall take a new inventory of all stocks o controlled substances on hand at least every two years. The biennial inventory may be taken on any date which is withi two years of the previous biennial inventory.

21 CFR 1304.21 General requirements for continuing records.

(a) Every registrant required to keep records pursuant to §1304.03 shall maintain on a current basis a complete an accurate record of each substance manufactured, imported, received, sold, delivered, exported, or otherwise disposed o by him/her, except that no registrant shall be required to maintain a perpetual inventory.

II. EVIDENCE PRESENTED

The following is a summary of the evidence presented and the analysis of that evidence with respect to the allegations in the Amended Complaint.

Patient Kenneth R.

The allegation is that on April 2, 2003, the Respondent purported to remove all of the decay and place proper fillings on the patient's teeth #6, #7, #8, #9, #10, #11, #12, #14 and #16. The allegation is that the Respondent redid tooth #8 on April 10, 2003. The evidence presented showed that on September 2, 2003, another DOC dentist, Dr. Hamman, examined the patient because of his complaints about pain in teeth #8 and #9, and found these teeth to have decay underneath the fillings and to beer poorly sealed. At the hearing, the Respondent maintained that the apparent cavities which appeared on the x-ray were not actual decay, but were air spaces which he created when he used the dental bur to remove healthy dentin for the purpose of achieving better mechanical adhesion of the filling material to the tooth.

The Respondent's explanation was refuted by Drs. Hamman and Morris, who testified that the standard of care in dentistry is t remove all decay before placing fillings. Dr. Hamman is a 1995 graduate of Case Western University and a graduate of a six-year oral and maxillofacial surgery program in San Antonio, Texas. Dr. Hamman has been employed as a dentist at DOC for eight years and prior to that worked in private practice. Dr. Morris is a senior partner in a private dental practice with over thirty years of experience and a professor of oral diagnosis and treatment at Marquette Dental School.

Upon examining the patient, Dr. Hamman found caries in teeth #8 and #9 and symptoms that were consistent with possible tooth necrosis. [Transcript at pg. 68]. In his opinion, the patient's teeth ultimately died as result of a bacterial invasion of the nerve space or the pulpal space, which he attributed to the failure of the Respondent to remove all of the decay underneath the fillings.

Dr. Hamman testified as follows:

> Q: What does this say about the treatment that Dr. Welsh rendered in April of 2003 when he filled both of these teeth?
>
> A: Based upon what I did with this gentleman and based upon ultimately what my restoration looked like, there was a significant amount of decay that was left in the teeth adjacent to where the fillings were placed. Decay removal wa inadequate. Subsequent to that, the tooth died because of the bacterial invasion of the area and just physical trauma, so i could have been a combination of factors, but there was a significant amount of decay left in the teeth. The way that know is by looking at my postoperative films before I provided root canal treatment, the size, extent of the fillings fa exceeded what was placed by Dr. Welsh, and as dentists, we always try to be as conservative as possible and not grin on a tooth to a horrific amount because we are using bonding agents. We basically want to remove all decay, unless there is more decay to remove, and that's what I did in my film. [Transcript at pp. 75-76]

Dr. Hamman further testified that it appeared that the overall fillings were intact, but there was decay visible through a substantial area of enamel itself which did not involve any overt violation of the filling material margin and the tooth structure. I Dr. Hamman's opinion, there was no other cause for such significant amount of decay other than all the carious material had no been removed. [Transcript at pg. 90] Dr. Morris testified that if the dark areas on these teeth, which appeared in four separat places, were intentionally created air spaces; they represented a failure by the Respondent to properly manipulate the resin fillin material so that it completely filled the excavated space. According to Dr. Morris, leaving air spaces in teeth unnecessarily increases the risk to the patient of tooth fracture, in that the tooth material over the air space is unsupported and therefore weaker than the rest of the tooth. Using the dental bur to remove additional healthy material beyond that which is necessary t remove decay, is no longer an acceptable dental technique. Modern resin material used with bonding agents is sufficient t bond the restorative resin to the tooth without the need for additional mechanical adhesion. If the spaces shown on x-ray are carious material, they represent failure by the Respondent to remove all carious material before restoring the tooth, thus increasing the danger to the patient of recurrent caries and the need for additional dental work.

Dr. Morris testified that the placement of restorations on these teeth by the Respondent was not within the standard of care fo dentistry because the radiographic evidence shows unremoved decay under the fillings placed in those teeth. [Transcript a

144-146]. Dr. Morris explained that the films clearly show the areas of filling and the very distinct darker shadow around the fillings, which is the unremoved decay. Dr. Morris further explained that unremoved decay will either cause a tooth to weaken to point of fracturing or it will reach into the nerve resulting in infection and abscesses. [Transcript at pg. 146]. Dr. Morris testified that the Respondent's failure to remove all of the decay material substantially departed from the standard of care ordinarily exercised by a dentist and an inability to apply the basic principles or skills of dentistry. [Transcript at pp. 146-148]

Dr. Morris's testimony made it abundantly clear that the dental treatment involved with this patient involved basic dental skills

> Again, we're really taking about A-B-Cs. Dentists fix cavities and make the preparation of the tooth. You open up the area, and you make sure you remove the decay. You do that sometimes with a drill carefully; sometimes if you're close to a nerve you may use a small hand instrument so that you don't go into the nerve unnecessarily, but you need to visually and tactilely verify that all decay is gone before you place a restoration in the tooth. [Transcript at pg. 147]

The preponderance of credible evidence shows that the Respondent's care and treatment of this patient was well below the minimally acceptable standards of dentistry and was a danger to the health, safety and welfare of the patient.

Patient Larry T.

The allegation is that on July 2, 2003, the Respondent failed to remove all of the decay prior to placing a filling in one of the patient's teeth and failed to properly polish two other fillings. The evidence showed that all of the decay was not removed from tooth #21 by the Respondent before he filled it, thereby leaving decay underneath the filling. The evidence also showed that the Respondent failed to properly polish two of the fillings for teeth #9 and #11. Another DOC dentist had to replace the filling in tooth #21 and re-polish the fillings in teeth #9 and #11 to remove significant flash and overhang which the Respondent failed to remove.

Dr. Morris examined the dental records of patient Larry T. and testified that the Respondent's failure to remove all of the decay from tooth #21 before filling it constituted a substantial departure from the standard of care in dentistry. Dr. Morris indicated that this was similar to the problem for inmate Kenneth R. [Transcript at pp. 149-50] Dr. Morris further testified that in addition to the decay problem, the Respondent's failure to remove the excess filling material was a substantial departure from the standard of care. He explained that when a filling is placed in a tooth, the dentist must not leave gross amounts of excess filling material on the edge of the tooth because it is harmful to tooth and gum tissues. Dr. Morris testified that the harm to the patient when a filling is not contoured contiguously with the tooth is that it becomes a food and bacteria trap which contributes to the failure of the filling as a result of more decay because the area is not cleansable. [Transcript at pp. 152-154]. Dr. Morris explained that every dentist is trained in dental school to trim away the excess filling material and to smooth and polish the filling so that it matches evenly with the surface of the tooth. [Transcript at pg. 154]. In Dr. Morris's opinion, the Respondent's failure to remove the excess filling material showed a lack of knowledge of basic dental principles and dental skills.

Dr. Flanagan, the DOC dentist who treated Larry T. on July 14, 2003, twelve days after the Respondent treated the patient testified that patient had complaints of pain, fever and a loose filling on tooth #21.[1] Dr. Flanagan has been a practicing dentist in private practice for 39 years, with no history of any disciplinary action by any dentistry board. Dr. Flanagan has been employed at the DOC since 2002. [Dep. at pp. 4-5]. Dr. Flanagan found the filling in tooth #21 was loose with the presence of decay below the gum line and underneath the composite filling. Dr. Flanagan also found an infected tract coming from the area and advised the patient that it was not a healthy situation. [Dep. at pp. 9-10] Dr. Flanagan's opinion was that a filling should not pop out 12 days after it has been placed. He testified that the reasons that the filling failed was due to the decay left underneath the tooth. [Dep. at pg. 13]. Dr. Flanagan also found that the fillings were not polished properly, resulting in areas that were not flush to the tooth structure. The unpolished area would tend to catch food particles and create other decay and gum disease. [Dep. at pp. 16-17] Dr. Flanagan testified that it is the standard of care in dentistry that a dentist must polish the tooth on the same day that he places the filling so that it meets the surface of the tooth smoothly. [Dep. at pg. 19]

Patient Vincent H.

The allegation is that on July 3, 2003, the Respondent over-instrumented the filing for a root canal on this patient, which resulted

in the gutta-percha filling penetrating the apex and entering the patient's maxillary sinus. It was also alleged that although the Respondent recognized his mistake, he failed to correct it, thus placing the patient at risk for sinus infection and loss of the tooth. The Respondent admitted at the hearing that he had over-extended his filing at least four-and-a-half millimeters beyond the apex. [Transcript at pg. 363] When asked to account for why he did not take immediate action to remove the gutta-percha as soon as he realized that he over-extended his filings, the Respondent testified that gutta-percha might break off and cause more harm than good. [Transcript at pg. 364] Yet, in an early deposition when asked why he did not remove the gutta percha, the Respondent testified as follows:

A: I had a pretty good rapport with the inmate patient, and I had advised him of the problems that I had, would have him come back and remove and reseal that tooth.

Q: Why didn't you just do it then?

A: At that time, I didn't have time.

Q: How long would it have taken to do?

A: Probably another 45-minute appointment to remove all that gutta-percha.

[Transcript at pp. 373-374]

The Respondent also testified that the proper root canal technique is to file all the way to the apex, thereby destroying the natural narrowing of the canal at the apex. [Transcript at pp. 369-371] The Respondent testified that gutta-percha is an inert substance that is very biocompatible with the body and it presented no risk of harm to the patient if it was left in the apex. [Transcript at pg. 365] The Respondent's testimony at the hearing was inconsistent with his early testimony under oath at his deposition. When asked the following questions about the possible risk of harm to the patient, the Respondent testified as follows:.

Q: Why are you taught that it should not be extended beyond the apex?

A: I am sure that it could cause some irritation.

Q: In your opinion is infection a potential danger to the patient?

A: It's a possibility.

[Transcript at pg. 374]

Q: So are you aware of any other risk or danger to the patient of having gutta-percha extend five millimeters into the - beyond the apex?

A: I'm sure that there is a possibility of maybe forming a cyst.

[Transcript at pg. 375]

Q: What bad things can happen if a piece of gutta-percha goes into the maxillary sinus area and stays there?

A: Well, we had discussed that before.

Q: Well, you mentioned a cyst could form.

A: The area could get reinfected.

Q: Anything else?

A: Maybe a sinusitis could form.

[Transcript at pp. 375-376]

Respondent's Expert Witnesses

The testimony of Drs. Willoughby and Skelding were relied upon by the Respondent to bolster his contention that the gutta-percha did not penetrate the patient's sinus. Dr. Willoughby, who was deposed prior to the hearing, testified that the patient's complaints of pain may have been due to a vertical fracture on the root of the tooth. Dr. Morris testified that if the tooth was vertically fractured, it would appear on the biting surface. If a root was fractured a cyst would develop on the side of the tooth and not on the ends. [Transcript at pp. 240-241]. Dr. Morris's opinion was more credible than Dr. Willoughby's testimony because it was consistent with the radiographic evidence and the findings of the DOC dentist who extracted the patient's tooth.

Dr. Willoughby also testified that he did not believe there was a perforation into the sinus because the patient did not have "oroantral communication." [Ex. X at pp. 12, 16] However, Dr. Willoughby's testimony was far from conclusive. When he was cross- examined, Dr. Willoughby admitted that a sinus perforation may not show up radiographically and a patient might not develop sinusitis, even though a perforation existed, because the body resealed the opening. [Ex. X at pp. 30-31]. Dr Willoughby admitted that he could not state to a reasonable degree of certainty whether or not the gutta-percha was in the patient's sinus. [Ex. X at p. 12]. Dr. Willoughby testified on this point as follows:

Q. During your direct testimony, you said, among other things, I want to be sure I understood this, that when Mr Sullivan was asking you about the signs and symptoms of sinusitis, you said that sinusitis would be reasonably expected to set in within a couple of weeks following a perforation if it did not resolve on its own.

A. Yes.

Q. What does that mean, if it doesn't resolve on its own?

A. Again, that is the difference between an oroantral communication, the sinus communication and a sinus fistula. Sinus communication is not mature. There is not an epithelialized tract between the mouth and sinus. If there is a perforation, and if it's small enough, it may form its own seal before it goes on to form a fistula. And, hence, resolving the communication before sinus infection sets in.

Q. If that happens --

A. Yes.

Q. -- would you expect then there would be no sinusitis because the seal had re-established, the body re-established a seal?

A. Yes. That is if it didn't develop from bacteria that did reach the sinus during that opening, which would typically become apparent after a few weeks.

Q. Is it a reasonable inference to draw from this testimony the fact that a patient does not develop sinusitis doesn't mean that there wasn't a perforation at all, it just means that if there was one, the body resealed it and the patient was fortunate enough to not have that complication develop?

A. Very reasonably.

Q. Do I understand your opinion to be then that we do not have enough evidence to show whether this patient's sinus wa penetrated by this gutta-percha? It may have been, but it may not have been, it's just not possible to know, given the evidence that we have.

A. That's correct. [Transcript at pp. 30-31]

Accordingly, Dr. Willoughby's testimony cannot be relied upon to establish that the gutta-percha was not placed by the Respondent beyond the apex. Nor was this contention established through the testimony of Dr. Skelding, which was offered in support of the Respondent's claim that the gutta-percha did not extend into the sinus. [Transcript at pg. 456] Dr. Skelding testified that the angle of the tooth to the x-ray would distort or affect the determination of whether the gutta-percha was actually in the sinus and he was reasonably certain that the gutta-percha had not penetrated the sinus. However, Dr. Skelding's testimony was more confusing than it was helpful as shown by the following portion of his testimony:

Q: Using the x-ray which shows the gutta-percha beyond the apex and Exhibit HH, if you can, explain to the ALJ where you believe the x-ray demonstrates the gutta-percha actually lies.

A: This is the maxillary sinus, and its made up of lobes, of channels. We have a channel here. We can see that, the septum and bone, the membrane into here. Same thing over here. Exists my biggest concern at this point in there and here. I just did that. I showed her.
[Transcript at pp. 444-445]

Dr. Skelding testified that the gutta-percha could weave itself up through the bone even when a channel had not been prepared for it:

Q: What is your explanation for how the gutta-percha could lie in the path that we see it as a straight and very slightly curved but with no curl at the end or anything like that as we see on this x-ray unless Dr. Welsh had, indeed, filed beyond the apex and into the tissue there?

A: Well, the bone in the upper jaw we call a soft bone as compared to the bone in the lower jaw. The term is spongy. It looks like a starfish, the bone does. And it's easy, not easy, but it is practical for a gutta-percha to weave its way up through the bone.

[Transcript at pp. 463-464]

Dr. Skelding's explanation of the gutta-percha weaving through the bone was inconsistent with the x-ray film submitted at the hearing which showed the gutta-percha lying in a well-defined slender channel pertruding into the sinus. The gutta-percha did not appear in a meandering or uneven channel that would be consistent with the material "weaving" through the bone. [Ex. L].

In addition, Dr. Skelding's credibility, expertise and objectivity to render the opinions he offered at the hearing wa questionable. He presented himself as having graduated from the Marquette Dental School with honors. [Transcript at pg 439] Yet, the official records of the Marquette Dental School did not corroborate this claim. Dr. Skelding also testified that he had significant expertise in radiology. The evidence showed that Dr. Skelding only practiced in that field for two years prior to attending dental school. [Transcript at pg. 439] Dr. Skelding has never taught dentistry students. Dr. Skelding had a smal town private practice and worked for a short time as a general dentist at DOC after selling his private practice. Dr. Skelding was terminated from his position at DOC. Even more troubling, Dr. Skelding appeared to have a personal antagonism to Dr Ripani, the DOC Dental Director. An illustration of Dr. Skelding's bias was shown in his earlier deposition when asked abou the DOC complaint; he testified as follows:

Q: … So everything tracks to one person- Ripani, Ripani, Ripani. And no one has done a check system what's going on here. How can one person do all this and find nothing wrong with any other dentist at DOC on any of these charts? She's going after one guy, it's obvious. She got rid of him, and how she went ahead and made the complaint. And that's why we are here today. It's Dr. Ripani. She's incompetent. [Transcript at pg. 290]

Q: Did any standard of care occur in the care of these patients by Dr. Welsh?

A: … it's blatant that Dr. Ripani has falsified these complaints knowingly and intentionally.

[Transcript at pg. 279]

Complainant's Expert Witnesses

Dr. Morris testified that based upon his review of the x-ray films and dental chart the gutta-percha gad penetrated the sinus. According to Dr. Morris this penetration was caused by the over-instrumentation by the Respondent. According to Dr. Morri in order for gutta-percha to get into the sinus, it would have to follow some kind of a path created by file because the gutta percha cannot penetrate the sinus itself. [Transcript at pg. 224] Dr. Morris explained that the gutta-percha becomes warn when it enters the canal and then softens and compresses.

Dr. Morris also refuted the Respondent's argument that penetration did not occur because the patient would have felt intens pain during the procedure when the sodium hypochlorite was used to irrigate the canal. He testified as follows:

Q. Okay. Now, both Dr. Welsh and Dr. Skelding testified that when irrigating the canal before -- after it had beer cleaned out but before the gutta-percha were placed in it that if in fact the canal had been over-instrumented and a tracl had been created into the area above the apex, that when irrigated the patient would have felt it because the irrigatio solution which contains bleach would have traveled up the track into the area of the -- I don't know, it's not really gum, bu --

A. Maxillary sinus.

Q. -- the maxillary sinus area or at least that tissue between the maxillary sinus and the tooth itself. In your opinion is this a correct statement?

A. It's highly unlikely.

Q. Why?

A. Several things here. One, the opening we're talking about here is not a huge defect. At the very largest it would be a size -- like a size 45 file and it would be in tissue. Two issues here. One is would the liquid have even gotten into the sinus in the first place, and I brought along a flushing syringe. This has water in it, not bleach, and basically the end of the syringe is dull. You have to look very close. The opening is on the side --

ALJ BAIRD: Like a needle, a sewing needle.

A. Right. So that when you squeeze, instead of the water shooting out the end it actually goes backwards, and that's the whole point because you do not want bleach solution to be squirted under pressure out the end of the tooth. In fact, t do so would be I think in itself potentially breach of standard of care, something that we take great pains to avoid. Fo example, if we know we have a working length of 20 millimeters, for example, we can bend that syringe so that when we place it in the tooth, we don't go beyond say 15, so that when we then squeeze, you don't see any water coming out the end of the root there but it's dripping out the bottom of the tooth. We would never push that needle all the way to the end and squeeze hard, and I'm trying to demonstrate this. I got to do it. Even there I can't get it to come out th end. Try the other canal. Take that out. Hard to get it to come out the end and I can't. There it is. There we go. But see there I'm actually pushing the syringe out the end of the root. See the little metal tip there?

A. And you would never -- you would never do that for the simple reason that you're using bleach which is intentionally used because it dissolves tissue which is great if you're cleaning out the inside of the root canal but not great if you get i someplace where it doesn't belong. So the first proposition that inevitably the bleach solution would have squirted out the end of that defect I believe is not -- not reasonable.

Q. Okay.

A. That most likely if this were done in a normal, appropriate technique, the bleach never would have reached the area.

> On the other hand, if it had gone somewhat beyond the end, that entire area is in fact anesthetized. When you do an infiltration anesthetic on an upper premolar, you're going to numb an area that is probably two or three inches wide and also goes in. That's the whole point. Now, if you injected enough bleach under enough pressure into the sinus, then maybe, yes, you would get -- you would get the patient to react once you got beyond the area of anesthesia. I don't believe that happened here, even though I do believe that the canal was over -- the file was overextended and I believe it was most likely to the sinus. I don't believe that bleach reached the sinus. However, had some gotten out there would have not necessarily been a sensation because of the anesthesia. [Transcript at pp. 623-26]:

Dr. Brevard testified that he extracted the patient's tooth on January 9, 2004. Dr. Brevard has worked at DOC for 12 years and has been a licensed general dentist for 34 years. He testified that the patient presented to him on an emergency basis with complaints of pain, a constant draining of the sinus, sinusitis and inflammation in that area. [Dep. at pp. 15, 23] After reviewing the patient's dental chart, Dr. Brevard concluded that the gutta-percha had penetrated the patient's sinus and this was causing the patient's pain and sinus problems. [Transcript at pp. 15, 21-22] Dr. Brevard testified that he found the gutta-percha on the roof of the sinus and he had to perform a peritone extraction to avoid the risk of leaving part of the gutta-percha in the sinus. [Transcript at pp. 12, 28] Upon extracting the tooth, Dr. Brevard also found a gelatinous cyst wrapped around the gutta percha indicating that the body had tried to wall off the material with a cyst. [Transcript at pp. 13, 42-43] In Dr. Brevard' opinion, if the gutta-percha had either not been over-extended or had been promptly removed and replaced with proper length the patient would not have suffered the resulting pain and sinus problems. [Transcript at pg. 15]

The greater weight of the evidence supports the finding that the gutta-percha penetrated the sinus due to the Respondent' over-extended filing. The Respondent's own entry in the patient's dental chart at the time he performed the root canal indicates that he recognized that he had overextended the filing. The evidence also shows that the Respondent failed to remove the penetrating gutta-percha as soon as he realized what he had done. The Respondent's failure to perform the correct filing length and take action to correct his over-filing caused harm to the patient. The evidence shows that the Respondent's treatment of this patient was below the minimum standards of care in dentistry.

Patient Larry P.

The allegation is that on August 29, 2003, the Respondent placed a stainless steel crown on this patient's tooth #12 which was too large for the tooth and not properly adapted or "crimped" to seal the tooth. This evidence consisted primarily of the testimony of Dr. Hamman, the subsequent treating dentist at DOC who replaced the ill-fitted stainless steel crown.

Dr. Hamman found that the Respondent's selection of the crown size selection and adaptation was inappropriate and inadequate. Dr. Hamman found that the patient's gum tissue was getting caught in the trap area and this in turn caused a low grade infection for the patient as a result of the poor size and adaptation. In layman's terms, Dr. Hamman described the situation as follows:

> It would be similar if you had a hat that was two sizes too big. If the materials of the hat were able to be moved in a way that would actually fit the size of your head, you would be able to wear it. The hat is too big. It is too big, and you're relying upon, you know, either your head getting larger or something of that nature to keep it from causing problems. [Transcript at pg. 27]

Dr. Hamman also testified that because the crown had not been "crimped" around the tooth at adequate levels, the curvature did not meet the appropriate contour of the tooth. In fact, Dr. Hamman testified that he saw no evidence of crimping whatsoever. Based upon the radiographs which Dr. Hamman took and the clinical intraoral findings, he determined that the best solution was to redo the stainless crowns placed by the Respondent.

The Respondent's explanation of his dental treatment for Larry P. was not persuasive or supported by the evidence submitted at the hearing. The Respondent first claimed that the DOC dental clinic did not have the proper equipment to adapt and "crimp" a stainless steel crown. This testimony was refuted by Dr. Hamman, who practiced at the location where this procedure was done, and confirmed that the proper dental tools (scissors, pliers, crimpers) were available. [Transcript at pg 60] The dental assistant, Ms. Kirchhoff, also testified that the proper equipment was stocked and she could have retrieved the tools for the Respondent from the marked tool baskets if he had requested them. [Transcript at pp. 577, 579, 580] The Respondent then attempted to justify his actions in selecting a larger crown size for Larry P. as maintaining the point of contac

between teeth #11 and #12, which were anchors for a six tooth denture. The Respondent testified that selecting a smalle crown could cause tooth #12 to "drift" and thus cause the denture to not fit, or could cause food to be caught between the teetl resulting in periodontal problems. This explanation was refuted by Dr. Robert Morris, who testified that the relative risk o periodontal problems is lower when a smaller crown is placed and properly adapted to the tooth surface, because a patient ca clean between the teeth with proper oral hygiene, but cannot clean underneath an insufficiently crimped and adapted crow base. According to Dr. Morris, the harm caused by failing to properly crimp and adapt the margin of the stainless steel crow is that there may be leakage which leads to recurrent decay, loss of tooth structure, tooth abscess and severe periodontal o gum response. [Transcript at pp. 129-130]

Dr. Morris also testified about the Respondent's dental care of this patient. Dr. Morris testified that he has placed maybe 50 t 100 stainless steel crowns in his dental career. He examined the radiographs in the patient's chart and concluded that th Respondent's departure from the standard of care ordinarily exercised by a dentist in placing such crowns was substantial. H testified as follows:

> It was substantial in that the margins were so ill-fitting, and then subsequently, I believe that Dr. Hamman was able t observe them clinically and found that there was puss and infection harboring beneath them which is consistent wit what the x-ray would suggest. [Transcript at pg. 129]

Dr. Morris testified that every competent dentist should know how to trim and crimp the edges of a stainless crown so that it i adapted tightly to the tooth. He explained this in the following testimony:

> Yes. Part of your dental education and the standard for any restoration, whether it is stainless steel; crown, gold crow silver filling, plastic filling, it needs to be adapted correctly and smoothly to the surface of the tooth. [Transcript at pg 132]

In Dr. Morris' opinion, the Respondent's conduct indicated a lack of knowledge of the basic principles and skills of dentistr and negligent application of the skills of dentistry. Dr. Morris testified that the use of a tooth as a support for the denture is les important than preventing the periodontal disease and infection that would result from an improperly adapted and crimpe crown base. Dr. Morris summarized his opinion in the following testimony:

> Well, again, this is really basic A-B-Cs. Whenever we work with the tooth and the gum line particularly, it needs to b cleansable, needs to be smooth so that is doesn't collect food and bacteria, needs to be maintainable by the patient. That's just very, very A,B,C, principles in any restorative dentistry. [Transcript at pg. 133]

Finally, in addition to his selection and adaptation of the crown, the Respondent failed to correctly record in the patient's denta chart that he had prescribed clindamycin as a pre-medication for the patient due to the patient's allergy to antibiotics in th penicillin family. Instead, the Respondent erroneously charted that he prescribed amoxicillin. This unnecessarily increased th risk that a future dentist, observing that amoxicillin had apparently been prescribed without incident, would actually prescrib amoxicillin, and thus cause an allergic reaction and serious harm to the patient. Respondent's charting for this patient was als below the minimum standards of dentistry, and constituted a danger to the health, safety and welfare of the patient.

Patient Michael R.

The allegation is that over the course of three separate occasions beginning on October 9, 2003, the Respondent provide temporary measures to relieve the patient's discomfort, but did not take reasonable steps to diagnose the cause of the patient' dental problems. The patient only had one arm which likely caused him difficulties in maintaining his oral hygiene, particularl the flossing of his teeth. The Respondent admitted that he did not x-ray the patient's teeth or review the prior x-rays, despit the fact that he had pulled the dental chart on several occasions to chart his progress notes.

Dr. Schettle, a graduate from the Marquette Dental School, and a practicing dentist since 1983, testified that he extracted th patient's tooth #31 on November 7, 2003, Dr. Schettle is currently employed as a general dentist at DOC where he ha worked since 1991. [Transcript at pg. 13] According to Dr. Schettle, the respondent's repeated application of a de-sensitize gel when the patient returned complaining of pain without an actual examination and review of the x-rays was below th standard of care. [Transcript at pp. 22-23] Dr. Schettle also testified that the dark area of radiolucency on tooth #31, woul

have contraindicated that placement of desensitizing gel on the buccals of the teeth and that failing to render appropriate treatment unnecessarily prolonged the patient's pain. [Transcript at pg. 19] Dr. Schettle testified that the standard of care would have required that any x-rays which were available at the time be reviewed, that the patient be properly examined and that a diagnosis be made as to the cause of the patient's pain. [Transcript at pg. 18]

Dr. Morris also reviewed the patient's dental records and testified that if the Respondent had performed a proper examination including a review of available x-rays, he would have known that tooth #31 had significant periodontal involvement with infection between the roots as well as a significant area of decay. Dr. Morris explained the harm caused to the patient by Respondent's conduct; significant periodontal infection and decay left untreated would lead to further serious problems and unnecessarily prolong the patient's pain. According to Dr. Morris, the Respondent's care and treatment of this patient substantially departed from the standard of care ordinarily exercised by a dentist under the same or similar circumstances.

The treatment rendered by the Respondent is another example of his failure to perform a basic dental skills and procedures consistent the minimum standards of dentistry. The Respondent failed to perform a thorough dental examination, take x-rays or review the patient's dental chart and prior x-rays, (readily available to him). As a result, the patient received ineffective treatment and endured unnecessary pain. Although the patient had pre-existing dental problems, the Respondent was still required under the minimum standard of care in dentistry to make a proper diagnosis and provide appropriate treatment to the patient when he saw him.

Patient Lucas E.

The allegation is that on October 15, 2003, during the course of surgically extracting tooth #14 for this patient, the Respondent gouged the root of tooth #13 and removed cortical bone from a virgin tooth. Respondent admitted only that he nicked or scored the root of the patient's adjacent tooth and removed a segment of the bone during the extraction, but he was not aware of any damage to the root of the adjacent tooth. However, the evidence showed that tooth #13 had to be subsequently extracted by another dentist as a result of Respondent's actions.

At the hearing, there was considerable argument about whether testimonial evidence concerning the damage to the tooth should be allowed into the record since the tooth had since been lost. The physical location of the tooth did not preclude the admission of testimony from witnesses who had actual knowledge of its existence and condition. Not only was the existence of the tooth established, but the following testimony persuasively confirmed the condition of the tooth prior to its disappearance:

Dr. Flanagan observed the tooth and testified as follows:

Q. Would you describe these marks of the dental bur as deep or shallow, as nicks or as gouges?

A. Gouges.

Q. Were they deep or shallow?

A. Relatively deep. They did not go through the nerve chamber. They were touching in spots. Not the nerve chamber, but the—where the root and the nerve flow through the root.

Q. Were there many such marks, or only a few?

A. Several. I did not count them.

Q. How many is several?

A. Six.

(Exhibit R, pp.6-7):

Dr. Hamman also observed the tooth and testified as follows:

Q. [Can] you describe in as great a detail as you can currently recall exactly what you saw about tooth number 13's root?

A. Again, I'll draw with a different color. I'll use purple. The continuity root form is indicated by blue, and the pulpal chamber in this tooth would be indicated where I'm now filling in with orange in between the blue lines. On the side of the tooth very close to the apex were marks, step marks, along those lines, where you would see 90 degree angles correspond to a dental burr being applied to the tooth structure in such a fashion so, this were the dental drill itself being placed in the socket during the course of sectioning the root structure, which is toward the center of this distance there is a distance in between both teeth, angle of the burr was taken to such an extreme that it engaged the portion of the root a multiplicity of times, that exact number of times I don't remember, four, five, three, it's immaterial. It was more than three, less than ten. I don't know. I didn't count the number of marks, but one of them was quite deep.

(Transcript, pp.106-07, and referring to Ex. D):

Dr. Ripani observed the tooth and testified at the hearing as follows:

Q. When you saw tooth number 13, what did you see? Describe tooth 13.

A. The tooth -- the root of the tooth was gashed with numerous burr cuts, and it was shocking basically to see that amount of damage to a tooth.

Q. Is this consistent with the description that he touched the tooth with the burr?

A. That would be -- that would be a very oversimplification of what the tooth truly looked like.

(Transcript at pp. 247-48)

Dr. Ripani also testified to the following:

Q. Would you describe whether or not your observation of the tooth is consistent with Dr. Welsh's description that he may have nicked it during the removal process?

A. The impression I got was the tooth was seriously damaged multiple times by a bur.

Q. And if you could describe what you saw that leads you to that conclusion.

A. The score marks on the root of the tooth were about five millimeters long. There were multiple score marks of that length, and if I had to recall what the depth of it was, it would be at least half the depth of a bur, half the depth of the—of the diameter of the bur.

(Transcript at pp.583-84):

The Respondent was aware that he was damaging the patient's cortical bone as shown by the following testimony:

Q. . . . It is true, is it not, that the bone between the teeth, the plates, buccal and lingual, are much softer than the tooth itself, isn't it?

A. Yes.

Q. And, therefore, you can feel the difference when the burr is going through tooth as opposed to when it's going through this much softer bone; correct?

A. You want to repeat that?

Q. Sure. You can feel the difference when the burr is going through tooth as opposed to when it's going through this much softer bone?

A. Yes.

Q. So you know when the burr is removing bone as opposed to when it's removing tooth structure; correct?

A. Yes.

(Transcript, pp.391-92)

The evidence shows that the Respondent failed to adequately control the dental hand piece, which resulted in significant damag to the healthy adjacent tooth, and increased bone loss secondary to the extraction. When asked to explain how these problem would have occurred, the Respondent testified it was because all of the dental assistants were busy with other doctors and h had to work alone. [Transcript at pg. 381] He testified that each dental assistant had a specific duty on that day and a coupl of doctors were on vacation. [Transcript at pg. 395] However, the Respondent gave a different explanation under oath in prior legal proceeding. The Respondent testified before the Wisconsin Employment Relations Commission (WERC) in 2004 that he did not wait for a dental assistant because he was scheduled to attend a seminar that afternoon. [Transcript at pg. 396] The Respondent had also claimed in an earlier interview that his error was not waiting for an assistant and not getting an x-ray. [Transcript at pp. 396-397]

Yet, at the hearing in this case, the Respondent flatly denied that the problems could have been avoided if he had simply waite for an assistant who could have irrigated the area and kept the field of vision clear so that he could see what he was doing. Thi is shown in the following testimony:

> Q: It's a fact, is it not, that had you waited for assistance, who could have assisted you by irrigating this area an keeping the field clear, you, in all probability, would have been able to see what you were doing and would not hav scored tooth number 13 with the burr; isn't that correct?
>
> A: No, I don't believe that.
>
> Q: You don't?
>
> A: No.
>
> [Transcript at pg. 397]

The evidence also shows that the adjacent tooth #13 was so deeply scored along a considerable length and toward the apex o the root, that it was considerably greater than a mere "nick" or a normal expected complication. Given the Respondent' inconsistent statements, and the lack of any credible explanation for his conduct, it must be concluded that the Respondent' dental care was sloppy, careless and indifferent to the dental health of this patient. Conduct of this type is wholly inconsisten with a professional dentist's duty to avoid complications and to use competent professional skills to avoid adverse outcomes fo the patient.

III. DISCIPLINE RECOMMENDED

The recommendation in this case is that the Respondent's license be revoked. This recommendation is based on the objective of professional discipline; deterrence, rehabilitation and protection of the public. *State v. Aldrich*, 71 Wis. 2d 206, 20 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre,* 41 Wis. 2d 481, 485 (1969). Protection of public is of paramount importance. The preponderance of the credible evidence shows that the Responden engaged in a pattern of conduct below the minimum standard of care in dentistry and that any action short of revocation woul not serve to protect the public The evidence adduced at the hearing shows that Respondent's dental practices at the DO were substantially deficient in many respects. These deficiencies were not confined to a single area of practice or procedure

but covered a gamut of procedures; filling of cavities, extraction of teeth, fitting of crowns and root canal procedures.

In addition, the evidence shows that the Respondent engaged in self-prescribing and use of controlled substances outside the legitimate scope of dentistry. This pattern of misconduct involved other licensees and family members. In order to obtain controlled substances for his personal use the Respondent engaged in various improprieties including misrepresentations and record-keeping violations, which reflect poorly on his general character and trustworthiness. Respondent's demeanor at the hearing was that of a person who tended to blame others for his problems; unwilling to take responsibility for his actions. He claimed that the practice conditions for dentists at DOC prevented him from meeting the standard of care, particularly with respect to periodontal care. The Respondent also argued that he was the victim of unjustified criticisms by other dentists at DOC. Throughout the hearing, he attempted to rationalize his misconduct as minor and not harmful to his patients. The Respondent's arguments were not persuasive and were not supported by credible evidence.

The issue in this case is not whether Respondent had interpersonal difficulties at DOC or whether he agreed with the DOC guidelines for periodontal care. The issue is whether the Respondent's dental practices deviated from the minimum level of care required under the prevailing standard of practice. There are not two separate standards of care, one for private practice and another in an institutional setting. Dr. Hamman testified that unequivocally, as a dentist who has considerable services both inside and outside of the prison system, the standard of care for the practice of dentistry is the same in both systems. There is no excuse for ill-performed basic restorative dental care. The greater weight of evidence clearly demonstrates that the Respondent's dental care and treatment did not meet the accepted minimum standard of care for dentistry.

The public has the right to expect minimal competency in those granted the privilege of licensure and protection from substandard practices. It is difficult to ascertain how the public's safety interests can be protected when such an extensive range of incompetencies are involved. It is equally difficult to reliably assure the public that deterrence and rehabilitation can be achieved when the Respondent has not shown any insight or acceptance of responsibility for his actions. Given the record before me, this ALJ feels that there is simply no way for a regulatory body to represent to the public through continued licensure that the Respondent is safe and competent to practice at this time. Revocation of licensure is necessary to ensure public protection from the Respondent's substandard practices and to deter others from engaging in such conduct.

IV. ASSESSMENT OF COSTS

The assessment of costs against a disciplined professional is authorized by sec. 440.22(2), Wis. Stats. and sec. RL 2.18, Wis Admin. Code. The Dentistry Examining Board has the discretion to impose all, some, or none of the costs of the proceeding. Wis. Stats. § 440.22 (2). Costs are typically assessed when there is a finding of unprofessional conduct. The recommendation in this case is that full costs be assessed against the Respondent because his actions made this proceeding necessary. The Respondent, and not others, should pay for the time and expenses of the staff who have been required to work on this case. The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions and are proportionate to those costs. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Since the Respondent is found to have engaged in unprofessional conduct, he should be held responsible for the full costs of this proceeding.

Based upon the record herein, the Administrative Law Judge recommends that the Wisconsin Dentistry Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein. The rights of a party aggrieved by this Decision to petition the Board for a rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal" information.

Dated this 15th day of May, 2006

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Colleen M. Baird

Administrative Law Judge

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[1] Dr. Flanagan was deposed prior to the hearing and his deposition was admitted to the record as evidence in this proceeding.