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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
DANIEL A. HUMISTON, D.D.S., RESPONDENT.	:	0002510

Division of Legal Services and Compliance[1] Case Nos. 11 DEN 105 and 12 DEN 058.

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

Daniel A. Humiston, D.D.S.
1337 N. Taylor Drive
Sheboygan, WI 53081

Wisconsin Dentistry Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Wisconsin Dentistry Examining Board (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Daniel A. Humiston, D.D.S., (dob: 9/27/1952) is licensed in the State of Wisconsin as a dentist, having license number 3227-15, first issued on September 23, 1983, and current through September 30, 2013. Respondent was granted a Class 1 sedation permit on June 11, 2007 to administer conscious sedation-enteral. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 1337 North Taylor Drive, Sheboygan, Wisconsin 53081.

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

Case No. 11 DEN 105

2. On or about November 4, 2011, Respondent inappropriately signed two medical release forms (forms) on behalf of and in the name of a medical doctor (Doctor A), without Doctor A's consent, in order to assist a third person (Donor A) under Doctor A's care, in becoming a plasma donor. Donor A subsequently submitted the forms to a plasma center.

3. Thereafter, Doctor A was contacted by the plasma center to confirm the authenticity of the signatures, purporting to be Doctor A's, on the forms for Donor A. The plasma center required the authorization of Doctor A and the authentication of the signatures on the forms, as a result of safety concerns related to medication being taken by Donor A, before Donor A would be permitted to donate plasma to the plasma center.

4. Doctor A informed the plasma center that he did not complete the signatures on the forms for Donor A.

Case No. 12 DEN 058

5. Patient A is a mentally disabled diabetic woman born on June 29, 1964.

6. On April 23, 2012, Patient A's sister brought Patient A to Respondent for dental hygiene prophylaxis and restoration of one tooth (procedure). Patient A requires sedation as she is non-cooperative with dental procedures.

7. Respondent planned to administer conscious sedation-parenterally through intravenous (IV) methods on Patient A during the procedure.

8. Respondent employed a retired hospital emergency room technician (technician) to start conscious sedation-parenterally through an IV drip on Patient A. The technician inserted the IV needle into Patient A and was dismissed from the area by Respondent before Patient A's IV drip was properly flowing.

9. At all times prior to and during the April 23, 2012 procedure on Patient A, Respondent was not properly licensed to administer conscious sedation-parenteral as he had not been granted a Class 2 permit by the Board. Additionally, Respondent has never been properly licensed to perform deep sedation or general anesthesia as he has not been granted a Class 3 permit by the Board.

10. Patient A's sister observed the Respondent conduct three separate attempts to restart Patient A's IV drip after the technician had left the area.

11. Patient A's sister observed the Respondent administer multiple injections of medication into Patient A's IV line before Patient A became drowsy and then fell asleep. Respondent told Patient A's sister that she could leave, and that she would be called when the procedures were finished.

12. Approximately one hour later, Respondent's office called Patient A's sister, who returned to Respondent's clinic. Patient A's sister found Patient A unconscious in the dental chair and unresponsive to Respondent gently slapping her face and calling her name.

13. Respondent told Patient A's sister that Patient A was fine, but needed to go home and sleep. Respondent and his staff placed Patient A in a wheel chair, and assisted Patient A's sister in loading Patient A, still unconscious, into the sister's van for the return trip to the group home where Patient A resides.

14. Patient A was turned away from the group home where she lives, because she was unconscious and, in the opinion of the manager of the group home, in need of medical attention.

15. Patient A's sister took Patient A to the local emergency room, where the physician diagnosed over sedation from the dental procedure and infiltration of the IV into the muscle. He administered naloxone to counteract the medication Respondent had administered, and when Patient A was conscious, had her eat to restore her blood sugar to a normal level.

16. The minimally acceptable standards of care for sedation of dental patients are detailed in Wis. Admin. Code § DE 11.09. They include the recording of a time-oriented anesthesia record containing the patient's vital signs and oxygen saturation levels every five minutes; the continuous evaluation of the patient's oxygenation, ventilation, and circulation; the recording of the name, dosage, timing, and route of administration of all medications; the continual presence of qualified and trained staff in addition to the dentist performing the dental procedures; and continuous monitoring of the patient by qualified staff after the completion of the procedure before dismissal from the clinic.

17. Respondent's record for his unlicensed administration of conscious sedation-parenterally through IV methods on Patient A during the April 23, 2012 procedure, does not include the amount of the medication administered to Patient A. Instead, his record stated:

> "Did I.V. sedation Used 4versed at 3 16, 1nubaine at 3 17, 2versed at 3 21, 1nubaine at 3 23, 1versed at 3 23, 1versed at 3 23, 1nubaine at 3 24, 1versed at 3 27, 1nubaine at 3 27, 1versed at 3 35 out at 4:30."

18. Respondent documented that he told the physician at the emergency room he had administered 10 mg. of Versed and 20 mg. of Nubaine.

19. Due to an enforcement action, Respondent agreed not to engage in IV sedation dentistry during the pendency of DLSC Case Number 12 DEN 058. Respondent executed a sworn statement to that effect on October 3, 2012.

20. Respondent has not practiced IV sedation dentistry since that date.

21. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Dentistry Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 447.07(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. By the conduct described in the Findings of Fact, Respondent violated Wisconsin Administrative Code §§ DE 5.02(1) and DE 5.02(3) by intentionally misrepresenting a physician's opinion about his patient's ability to safely donate plasma.

3. By the conduct described in the Findings of Fact, Respondent violated Wisconsin Administrative Code §§ DE 5.02(1), DE 5.02(2), DE 5.02(5), DE 5.02(16) and DE 11.09 by failing to comply with the minimally acceptable standards of care in performing sedation dentistry on Patient A.

4. By the conduct described in the Findings of Fact, Respondent violated Wisconsin Administrative Code §§ DE 5.02(3), DE 11.06, and DE 11.07 by performing conscious sedation-parenteral and deep sedation on Patient A when he was not licensed to do so.

5. As a result of the above violations, Respondent Daniel A. Humiston, D.D.S., is subject to discipline pursuant to Wis. Stat. § 447.07(3)(a), (f), and (h).

ORDER

1. The attached Stipulation is accepted.

2. The license of Respondent Daniel A. Humiston, D.D.S., (license no. 3227-15), to practice dentistry in the State of Wisconsin is SUSPENDED for 30 days beginning on July 19, 2013.

3. The Class 1 and Class 2 sedation permits previously granted to Respondent Daniel A. Humiston, D.D.S., are indefinitely SUSPENDED for a minimum of six months from the date of this Order and until such time as he satisfies the Board that he is competent to perform enteral and parenteral conscious sedation with safety to the patient and the public, and that he is willing and able to comply with the minimally acceptable standards of care described in Wis. Admin. Code § DE 11.09. Respondent Daniel A. Humiston, D.D.S., may petition the Board at any time after six months from the date of this Order for the lifting of this suspension, on proof that he has successfully completed all training required by Wis. Admin. Code §§ DE 11.05 and DE 11.06 within the immediately preceding twelve months, and with evidence satisfactory to the Board that he has adequate staff and is able and willing to comply with Wis. Admin. Code § DE 11.09.

4. Subsequent to the 30 day suspension referenced in paragraph 2 above, Respondent Daniel A. Humiston's license to practice dentistry is LIMITED by the following conditions:

> a. Prior to the lifting of the suspension referenced in paragraph 2 above, Respondent Daniel A. Humiston, D.D.S., shall obtain four hours of continuing dental education in the topic of ethics for dentists, and four hours of continuing dental education in the topic of management of patients with complex medical histories. The course or courses shall be pre-approved by the Department Monitor, and shall require Respondent's physical presence in the same place as the instructor. No part of the continuing education credit may be applied to any other continuing education requirement to which Respondent may be subject.

b. If the sedation permits previously granted to Respondent Daniel A. Humiston, D.D.S., are re-instated pursuant to Paragraph 3 of this Order, the following conditions will apply:

i. Respondent Daniel A. Humiston, D.D.S., may practice conscious sedation dentistry only on patients who meet the criteria of class one in the American Society of Anesthesiologists' physical status classification system (normal, healthy patients without organic, physiologic or psychiatric disturbance).

ii. Prior to performing any conscious sedation, Respondent Daniel A. Humiston, D.D.S., shall obtain a professional mentor, who will monitor his conscious sedation practice.

a. Respondent shall locate and retain the professional mentor, who shall be fully qualified to use conscious sedation in dental practice, and who shall have been using conscious sedation in dental practice regularly during the preceding five years. The professional mentor must have both a Class 1 and Class 2 sedation dentistry permits. The professional mentor must be pre-approved by the Board.

b. Respondent shall provide the mentor with a list of every patient on whom he has practiced conscious sedation in the preceding three months; the mentor shall select five patients or 25% of the list, whichever is greater, for review. Respondent shall provide the mentor with the complete patient file for each patient the mentor selects.

c. The mentor shall review the patient file with particular attention to issues of patient selection and patient management, including attention to patient evaluation done by Respondent. The mentor shall evaluate the files for the appropriate and safe use of conscious sedation by Respondent, and shall file a report of the mentor's evaluation process and conclusions, with specific supporting references to the cases the mentor has reviewed, on a quarterly basis. The mentor shall file this report with the Department Monitor at the address below.

d. On or after January 1, 2018, Respondent may petition the Board to lift this limitation. At the time Respondent makes the petition, he shall provide the Board with all evidence the Board requests to demonstrate that the limitation is no longer appropriate or necessary. The Board, in its sole discretion, may grant, deny or modify the petition. Denial of a petition in whole or in part shall not be considered a denial of a license within the meaning of Wis. Stat. § 227.01(3)(a).

e. Respondent may not apply for a permit to perform any other class of sedation under Wis. Admin. Code ch. DE 11 while his license is limited pursuant to this Order.

5. Within 90 days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of $3,100.00.

6. All petitions and payment of costs, made payable to the Wisconsin Department of Safety and Professional Services, shall be sent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935, Madison, WI 53708-8935
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

7. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered, Respondent's license (3227-15) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs.

8. This Order is effective on the date of its signing.

WISCONSIN DENTISTRY EXAMINING BOARD

by: _____ 7/10/13
A Member of the Board Date