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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF THE PETITION FOR SUMMARY SUSPENSION AGAINST	:	
	:	DLSC Case Nos. 13 DEN 001
JEFFREY J. BECKER, D.D.S.,	:	13 DEN 124 and 13 DEN 129
RESPONDENT.	:	

ORDER 0003084

ORDER OF SUMMARY SUSPENSION

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The Petition for Summary Suspension dated July 28, 2014, was noticed to be presented at 10:00 a.m., or as soon thereafter as the matter could be heard, on August 5, 2014, in Madison, Wisconsin. At that time, Attorney Sandra L. Nowack appeared for the Petitioner, Department of Safety and Professional Services, Division of Legal Services and Compliance. Jeffrey Becker, D.D.S, Respondent, appeared by telephone.

Attorney Chad J. Zadrazil, designee for the Wisconsin Dentistry Examining Board, having considered the sworn July 28, 2014, Petition for Summary Suspension and attached Exhibits of Sandra L. Nowack; the Affidavit of Hannah Whaley; the Affidavit of Dr. Joseph Best, D.D.S. and Ph.D.; the affidavit of Service by Zachary P. Hendrickson dated July 28, 2014 confirming that a true and accurate copy of the Notice of Presentation of Petition for Summary Suspension dated July 28, 2014, Petition for Summary Suspension dated July 28, 2014, Affidavit of Hannah Whaley dated July 28, 2014 and Affidavit of Dr. Joseph Best, D.D.S. were sent by mail, on July 28, 2014, in an envelope properly stamped and addressed to the Respondent and his attorney of record, and; having heard the arguments of counsel and Respondent, hereby makes the following Findings of Fact, Conclusions of Law and Order:

FINDINGS OF FACT

1. Respondent Jeffrey Becker, D.D.S., (DOB September 8, 1958), is licensed in the state of Wisconsin to practice dentistry, having license number 4706-15, first issued on July 21, 1995, and current through September 30, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is Affordable Dentures 6015 West Forest Home Avenue, Unit 1, Milwaukee, Wisconsin 53220.

2. Respondent is also licensed to practice dentistry in the State of Ohio, pursuant to license number 30-018193, which was issued on July 7, 1986.

3. In November 2011, Chief Administrative Law Judge John J. Mulrooney, II, (ALJ) with the United States Drug Enforcement Administration (DEA) held a hearing on the merits of allegations that Respondent Jeffrey J. Becker, D.D.S., had violated federal law concerning controlled substances. On December 21, 2011, the ALJ issued an order in which the ALJ made factual and legal determinations to a preponderance of the evidence.

4. On November 16, 2012, Michele M. Leonhart, Administrator of the United States Drug Enforcement Administration (DEA) revoked Respondent's DEA certificates of registration (COR) numbers FB2238865 (Norwalk, Ohio) and BB0569775 (Milwaukee, Wisconsin), effective January 4, 2013. That order was published in the federal register at *Jeffery J. Becker, D.D.S.*, 77 Fed.Reg. 234, 72387 (Dec. 5, 2012).

5. Administrator Leonhart upheld the ALJ's decision based on the existence of substantial evidence supporting the ALJ's findings that the interests of the public required revocation of Respondent's DEA COR's, including the Milwaukee registration. See 21 U.S.C. § 823(f) and 824(a).

COUNT I

6. Administrator Leonhart and the ALJ found that:

   a. Between at least 2009 and 2012, Respondent had two dental practices in Norwalk and Avon, Ohio. Respondent had a DEA COR applicable only to the Norwalk location.

   b. Because Respondent did not have a DEA COR for the Avon location, he could not legally dispense or distribute controlled substances at the Avon location. See 21 U.S.C. § 822(e), 21 C.F.R. §§ 1301.12(a) and (b).

   c. Between December 2009 and November 2011, Respondent dispensed controlled substances at the Avon location without a valid DEA COR for the Avon location, in violation of 21 C.F.R. §§ 1301.12(a) and (b).

d. After December 2009, Respondent knew that he was in violation of the requirement that he have separate DEA CORs at each location at which he dispenses controlled substances.

e. At all times between December 2009 and approximately one week before the November 1, 2011 DEA hearing, Respondent knowingly continued to dispense controlled substances at the unregistered Avon office.

f. Between December 2009 and November 2011, although Respondent continued to dispense controlled substances at the unregistered office, Respondent did not apply for a COR at the Avon office.

g. Respondent's acts in knowingly continuing to dispense controlled substances at the unregistered Avon office constituted a "flagrant" violation of 21 C.F.R. § 1301.12.

7. Under the facts of this case, 21 C.F.R. § 1301.12 is a law substantially related to the practice of dentistry.

8. Respondent's conduct in violating a law substantially related to the practice of dentistry is unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15).

COUNT II

9. Administrator Leonhart and the ALJ further found that:

a. On numerous occasions between December 2009 and November 2011, Respondent transported controlled substances to the unregistered Avon office. The controlled substances were transported and stored in a plastic storage bin, about the size of a shoebox.

b. On multiple occasions before December 2009, Respondent left controlled substances unattended on a counter in the unlocked Avon sterilization room, in the open plastic storage bin.

c. The controlled substances Respondent improperly stored and dispensed at the Avon office included fentanyl, diazepam and midazolam.

d. Respondent's conduct in leaving the unattended controlled substances in an open portable plastic container violated 21 C.F.R. § 1301.75(b), which requires controlled substances to be kept in a securely-locked and substantially constructed cabinet.

10. Under the facts of this case, 21 C.F.R. § 1301.75(b) is a law the circumstances of which substantially relate to the practice of dentistry.

11. Respondent's conduct in violating a law substantially related to the practice of dentistry is unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15).

COUNT III

12. Administrator Leonhart and the ALJ further found that:

a. Between approximately 2009 and 2011, Respondent did not create or maintain required purchase records and order forms (DEA222) for the schedule II controlled substances he dispensed in the Avon office.

b. In failing to create or maintain required purchase records and order forms for the schedule II controlled substances he dispensed in the Avon office, Respondent committed serious violations of 21 C.F.R. §§ 1304.04(f) and (g).

13. By the acts described in paragraph 12, above, Respondent has engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(18), by failing to maintain records and inventories as required by the United States Department of Justice Drug Enforcement Administration.

14. Administrator Leonhart and the ALJ further found that:

a. On or about, between at least March and April 2009, Respondent had a mental or psychological condition that rendered him unable to safely and reliably engage in the practice of dentistry.

b. Respondent was frustrated with "trials of psychiatric medication and side-effects that included concentration diminishment and mood liability."

c. In November 2011, Respondent's professional commitments caused stress that, in his view, contributed to his mental health difficulties.

d. "Some" of Respondent's stress-related mental health difficulties were ameliorated when, in 2010, he gave up a teaching position.

e. As of November 2011, when Respondent administered controlled substances for the purpose of conscious sedation, it was his practice to write the administered doses on a paper towel and transfer those numbers to sedation logs later.

f. As of November 16, 2012, Respondent did not accept responsibility for violations of the requirement that he have a COR for his Avon office.

15. During the DEA proceeding, Dr. Daniel Becker, D.D.S., then Associate Director of Education in the General Dental Practice Department at Miami Valley Hospital, Dayton, Ohio

and Associate Editor of Anesthesia Progress for the American Dental Society of Anesthesiology testified as an expert.

16. Dr. Daniel Becker reviewed forty-three records of IV sedation that Respondent administered and found incompetent record keeping in Respondent's failure, contemporaneous to administration of the medications, to record vital signs.

17. Dr. Daniel Becker concluded that Respondent administered controlled substances, including midazolam, fentanyl, and diazepam in staggering doses and Respondent's work with controlled substances was below the standard of practice.

18. During the DEA hearing, Respondent admitted that his documentation indicated that he dispensed unusually large amounts of midazolam.

19. Respondent claimed, however, that the extraordinarily large amounts of midazolam were necessary because he specialized in difficult patients referred to him by other dentists. The ALJ and Administrator Leonhart determined that Respondent was not credible on this issue.

20. The ALJ and Administrator Leonhart determined that Dr. Daniel Becker's testimony was authoritative, consistent, and reasonable; they afforded Dr. Daniel Becker's testimony significant weight.

21. Administrator Leonhart noted that Respondent's testimony was:

> Intermittently inconsistent, implausible, and periodically lacking in detail. There were some issues, such as his background, education, and mental health issues, where his testimony had sufficient indicia of reliability to be credited, and there were other matters, several of which were in conflict with other evidence, where his version of events must be found to be less than completely credible.

22. Finally, Administrator Leonhart wrote:

> Clear on the evidence presented here, is that far from demonstrating acceptance and contrition, the Respondent has violated the law, disagrees with the law, and has continued to violate the law even after the Agency served him with an OSC.

COUNT IV

Patient JDT

23. On November 20, 2012, Patient JDT, whose date of birth was never recorded in Respondent's record, presented to Respondent for a "full mouth extraction and dentures." (A document from the Veteran's Administration (VA) reported Patient JDT's birth date as December 23, 1947)

24. Respondent's record of the care provided to Patient JDT identifies Patient JDT with two different last names, which are close in spelling.

25. On November 20, 2012, Patient JDT reported the following pertinent medical history:

a. Bad reaction to Anesthesia (Novocain);
b. Heart attack or heart problems (four myocardial infarctions since 1990);
c. Heart murmur;
d. Stroke (three in 1997);
e. High blood pressure;
f. Fainting spells or seizures;
g. Daily aspirin;
h. Smokes tobacco products; and
i. Current medications: fluoxetine, clonazepam, warfarin, lopermide, trazodone, simvistatin, metropol, ompeprozole, vitamin, and baby aspirin.

26. Respondent appropriately communicated with the VA regarding the warfarin, an anticoagulant, with a plan for Patient JDT to stop taking the warfarin and undertake a bridging protocol before and after the procedure.

27. Respondent did not inform Patient JDT of risks associated with Patient JDT's medical history or multiple myocardial infarctions since 1990, multiple transient ischemic attacks since 1997 and no comment as to the patient's positive response to the question "Bad reaction to anesthesia (Novocain?)."

28. Despite the fact that Patient JDT had been on anticoagulation therapy, Respondent took no additional local measures to manage the heightened risk of excessive post-operative bleeding, such as Gelfoam®, which would have created a scaffold for clot formation, or any other packing of the sockets after extraction.

29. Respondent's failure to take additional local precautions to manage the heightened risk of excessive post-operative bleeding in an individual on anticoagulation therapy was below the standard of minimal competence.

30. Respondent's failure to take additional precautions to manage the heightened risk of excessive post-operative bleeding in an individual on anticoagulation therapy created the unacceptable risk that Patient JDT would experience excessive blood loss.

31. Respondent's conduct as described in paragraphs 23-30 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT V

32. On December 10, 2012, Respondent gave Patient JDT local anesthetic in access of the maximum dose recommended. Patients with JDT's cardiovascular and stroke risk should not be given epinephrine doses exceeding 0.04 mg. Respondent gave the patient 0.256 mg of epinephrine.

33. The combined total local anesthetic dose (272 mg of lidocaine and 544 mg of Citanest® (prilocaine)) is roughly double the maximum dose recommended for an average adult.

34. The act of administering twice the recommended maximum dose of prilocaine and lidocaine to Patient JDT is practice below the standard of minimal competence.

35. In administering twice the recommended maximum dose of prilocaine and lidocaine to Patient JDT, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

36. Respondent's conduct as described in paragraphs 32-35 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT VI

37. Respondent did not document any evidence that Patient JDT was larger than an average person such that twice the recommended maximum dose was safe.

38. Respondent's failure to document if Patient JDT was sufficiently large in stature such that twice the recommended maximum dose would not create an unacceptable risk of harm indicates a lack of knowledge of, an ability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

39. Respondent's conduct as described in paragraphs 37 and 38 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT VII

40. Respondent ordered an intra-op panorex x-ray to be taken, but did not document it in the operative note.

41. The x-ray, although non-diagnostic in quality, demonstrates a retained root in the #29 area.

42. Respondent failed to document the retained root, and failed to inform Patient JDT of the retained root.

43. Respondent's failure to document the x-ray or the retained root in the #29 area, and his failure to inform Patient JDT is conduct which indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

44. Respondent's conduct as described in paragraphs 40-43, constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT VIII

45. After the full mouth extraction, Respondent failed to provide Patient JDT with follow up instructions or failed to document having done so.

46. Respondent's conduct in failing to provide Patient JDT with follow up instructions or failure to document having done so indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

47. Respondent's conduct as described in paragraphs 45-46, constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT IX

48. Respondent did not stop Patient JDT's bleeding before discharging Patient JDT.

49. When Patient JDT left the office, his skin was grayish; he was shaking profusely and bleeding heavily.

50. After Respondent discharged him, Patient JDT was hospitalized with bleeding which did not subside until December 18, 2012.

51. Respondent's decision to discharge Patient JDT, with excessive bleeding and without post-operative instructions, under the circumstances of this case, was below the standard of minimal competence because it created an unacceptable risk that Patient JDT's bleeding would not be controlled, leading to shock and possible death.

52. Respondent's conduct as described in paragraphs 48-51 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT X

Patient LWS

53. On May 30, 2012, Patient LWS, DOB September 15, 1946, presented to Respondent for full mouth extraction.

54. During the procedure, Respondent administered eight (8) carpules of 2% lidocaine, with 1:100,000 epinephrine.

55. During the same procedure, Respondent administered nine (9) carpules of 4% prilocaine.

56. Each carpule contains 1.7 to1.8 ml of local anesthetic solution.

57. The combined total local anesthetic dose (272 mg of lidocaine and 612 mg of prilocaine) is roughly double the maximum dose for an average adult.

58. In administering the combined doses of prilocaine and lidocaine to Patient LWS, Respondent's practice fell below the standard of minimum competence.

59. In administering the combined doses of prilocaine and lidocaine, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

60. Respondent's conduct as described in paragraphs 53-59 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XI

61. Respondent did not document any evidence that Patient LWS was larger than an average person such that the amount of prilocaine and lidocaine in excess of the recommended maximum dose did not create an unacceptable risk of harm.

62. If Patient LWS was sufficiently large in stature such that the volume in excess of the recommended maximum dose would not have created an unacceptable risk of harm, Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

63. Respondent's conduct as described in paragraphs 61 and 62 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XII

Patient MHG

64. On November 13, 2012, Patient MHG, DOB July 10, 1959, a female patient who smoked and had diabetes, presented to Respondent for full mouth extraction. Respondent ordered a panoramic radiograph, which was completed.

65. On December 10, 2012, Respondent performed the full mouth extraction.

66. During the procedure, Respondent administered nine (9) carpules of 2% lidocaine, with 1:100,000 epinephrine.

67. During the same procedure, Respondent administered eight (8) carpules of 3% Carbocaine® (mepivacaine hydrochloride).

68. The combined total local anesthetic dose (306 mg of lidocaine and 408 mg of mepivacaine hydrochloride) is roughly double the maximum dose recommended for an average adult.

69. In administering twice the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent's practice fell below the standard of minimum competence.

70. In administering twice the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

71. Respondent's conduct as described in paragraphs 64-70 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XIII

72. Respondent ordered a post-procedure radiograph which revealed that Respondent had left retained root fragments for #2 and #15.

73. Respondent failed to document the retained root fragments, which is conduct below the standard of minimal competence in record keeping, and created an unacceptable risk that a subsequent care provider would be unaware of the issue and it would go untreated.

74. Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

75. Respondent's conduct as described in paragraphs 72-74 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XIV

76. Respondent failed to inform Patient MHG of the retained root fragments.

77. Respondent's failure to inform Patient MHG that he left behind retained root fragments fell below the standard of minimal competence and created the unacceptable risk of post-operative infection and pain.

78. Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

79. Respondent's conduct as described in paragraphs 76-78 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XV

Patient EKG

80. Approximately between October 26, 2010 and May 8, 2012, Respondent provided periodontic treatment, including extraction and placement of implants, to Patient EKG, DOB May 19, 1935.

81. Respondent never documented an initial examination of Patient EKG.

82. Respondent's documentation of Patient EKG's treatment plan lacked pertinent information such as the planned number and position of the implants to be placed, or whether any bone grafting would be required. Respondent's treatment planning therefore fell below the standard of minimal competence within the profession of dentistry.

83. Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

84. Respondent's conduct as described in paragraphs 80-83 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XVI

85. Patient EKG had severe maxillary atrophy and virtually no posterior bone available in which to place the implants.

86. Respondent did not measure available bone from the available panorex x-ray.

87. Despite the lack of this pertinent information and the severe maxillary atrophy, Respondent documented that Patient EKG was a "good candidate" for implants.

88. A minimally competent dentist would have known that Patient EKG was not a good candidate for immediate implants, and that Patient EKG would require extensive bone grafting before the dentist could safely execute a treatment plan that included 3-4 implants in the maxilla.

89. Respondent's failure to recognize the significance of Patient EKG's severe maxillary atrophy, failure to recognize the significance of a lack of posterior bone available, and failure to measure and document available bone constituted conduct below the standard of minimal competence.

90. Respondent's incompetent practice created the unacceptable risk that the implants would fail and that Patient EKG would undergo painful and otherwise unnecessary procedures.

91. Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

92. Respondent's conduct as described in paragraphs 85-91 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XVII

93. On October 26, 2010, Respondent performed oral surgery on Patient EKG. Respondent failed to document anesthetics administered during the surgery.

94. Respondent's failure to document all anesthetics administered during oral surgery creates an unacceptable risk of overdose or that overdose will go unrecognized.

95. By failing to document all anesthetics administered during oral surgery, Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

96. Respondent's conduct as described in paragraphs 93-95 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XVIII

97. On May 8, 2012, during another procedure, Respondent administered seven (7) carpules of 2% lidocaine, with 1:100,000 epinephrine.

98. During the May 8, 2012 procedure, Respondent administered seven (7) carpules of a drug identified only as "other".

99. Respondent's failure to document the name of the drug he administered on May 8, 2012, is below the standard of minimal competence in the profession of dentistry. Pursuant to Wis. Admin. Code § De 11.09(3), documentation of the name of the medication administered must be documented in writing.

100. Respondent's failure to document the drug he administered during surgery created an unacceptable risk that Patient EKG would suffer an overdose or that an overdose would go unrecognized.

101. Respondent's conduct as described in paragraphs 97-100 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XIX

102. On November 27, 2012, during another procedure, Respondent administered eight (8) carpules of 2% lidocaine, with 1:100,000 epinephrine.

103. During the same procedure, Respondent administered six (6) carpules of 3% mepivacaine hydrochloride.

104. The combined total local anesthetic dose (272 mg of lidocaine and 306 mg of mepivacaine hydrochloride) exceeds the maximum dose recommended for an average adult.

105. In administering more than the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent's practice fell below the standard of minimum competence.

106. In exceeding the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

107. Respondent's conduct as described in paragraphs 102-106 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XX

108. Respondent did not document any evidence that Patient EKG was larger than an average person such that the amount of prilocaine and lidocaine in excess of the recommended maximum dose did not create an unacceptable risk of harm.

109. If Patient EKG was sufficiently large in stature such that the volume in excess of the recommended maximum dose would not have created an unacceptable risk of harm,

Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

110. Respondent's conduct as described in paragraphs 108 and 109 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XXI

Patient DAG

111. On November 26, 2012, Respondent administered to Patient DAG, DOB June 9, 1967, eight (8) carpules of 2% lidocaine, with 1:100,000 epinephrine.

112. During the same procedure, Respondent administered six (6) carpules of 3% mepivacaine hydrochloride.

113. The combined total local anesthetic dose (272 mg of lidocaine and 306 mg of mepivacaine hydrochloride) exceeds the maximum dose recommended for an average adult.

114. In exceeding the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent's practice fell below the standard of minimum competence.

115. In exceeding the maximum dose of lidocaine and mepivacaine hydrochloride, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

116. Respondent's conduct as described in paragraphs 111-115 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XXII

117. Respondent did not document any evidence that Patient DAG was larger than an average person such that the amount of prilocaine and lidocaine in excess of the recommended maximum dose did not create an unacceptable risk of harm.

118. If Patient DAG was sufficiently large in stature such that the volume in excess of the recommended maximum dose would not have created an unacceptable risk of harm, Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

119. Respondent's conduct as described in paragraphs 117 and 118 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XXIII

Patient MDDT

120. On August 1, 2012, Patient MDDT, DOB March 23, 1933, a female patient, presented to Respondent for oral surgery.

121. During the procedure, Respondent administered seven (7) carpules of 2% lidocaine, with 1:100,000 epinephrine.

122. During the same procedure, Respondent administered seven (7) carpules of 4% prilocaine.

123. The combined total local anesthetic dose (238 mg of lidocaine and 476 mg of prilocaine) exceeds the maximum dose recommended for an average adult.

124. In exceeding the maximum dose of prilocaine and lidocaine, Respondent's practice fell below the standard of minimal competence.

125. In exceeding the maximum dose of prilocaine and lidocaine, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

126. Respondent's conduct as described in paragraphs 121-125 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XXIV

127. Respondent did not document any evidence that Patient MDDT was larger than an average person such that the amount of prilocaine and lidocaine in excess of the recommended maximum dose did not create an unacceptable risk of harm.

128. If Patient MDDT was sufficiently large in stature such that the volume in excess of the recommended maximum dose would not have created an unacceptable risk of harm, Respondent's conduct indicates a lack of knowledge of, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

129. Respondent's conduct as described in paragraphs 127 and 128 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XXV

130. During the course of treating Patient MDDT, Respondent ordered panoramic radiographs on the following dates:

July 31, 2012
August 14, 2012
September 16, 2012
July 8, 2013
August 13, 2013 and
September 16, 2013

131. The radiographs identified in paragraph 130, above, were not of sufficient quality to be relied upon for diagnostic purposes.

132. Respondent failed to cause the radiographs to be taken properly or be retaken, failed to document their insufficient diagnostic quality and failed to inform Patient MDDT of the insufficient quality of the radiographs.

133. Because the radiographs were of insufficient quality, Respondent could not reasonably have relied on them in diagnosing and treating MDDT.

134. In exposing Patient MDDT to repeat radiation exposure for radiographs he could not have reasonably relied on, Respondent unnecessarily exposed Patient MDDT to radiation.

135. Radiation is cumulative over a person's lifetime.

136. Unnecessary radiation exposure creates an unacceptable risk of cancer and is conduct which falls below the standard of minimal competence in the practice of dentistry.

137. Respondent's conduct as described in paragraphs 130-136 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XXVI

Patient FWD

138. On February 20, 2012, Patient FWD, DOB May 26, 1975, presented to Respondent for oral surgery.

139. During the procedure, Respondent administered nine (9) carpules of 2% lidocaine, with 1:100,000 epinephrine.

140. The local anesthetic dose (306 mg of lidocaine) exceeds the maximum dose recommended for an average adult.

141. In administering more than two times the maximum dose of lidocaine, Respondent's practice fell below the standard of minimum competence.

142. In exceeding the maximum dose of lidocaine, Respondent created the unacceptable risk of overdose, including seizures, coma, respiratory arrest and depression of the cardiovascular system.

143. Respondent's conduct as described in paragraphs 138-142 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), because it was a practice constituting a substantial danger to the health, welfare or safety of a patient or the public.

COUNT XXVII

144. Respondent did not document any evidence that Patient FWD was larger than an average person such that the amount of lidocaine in excess of the recommended maximum dose did not create an unacceptable risk of harm.

145. If Patient FWD was sufficiently large in stature such that the volume in excess of the recommended maximum dose would not have created an unacceptable risk of harm, Respondent's conduct indicates a lack of knowledge, an inability to apply or the negligent application of principles or skills of dentistry in violation of Wis. Stat. § 447.07(3)(h).

146. Respondent's conduct as described in paragraphs 144 and 145 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

COUNT XXVIII

147. During the February 20, 2012 procedure, Respondent administered six (6) carpules of a drug identified only as "other".

148. Respondent's failure to document the name of the drug he administered on February 20, 2012, is below the standard of minimal competence in the profession of dentistry. Pursuant to Wis. Admin. Code § De 11.09(3), documentation of the name of the medication administered must be documented in writing.

149. Respondent's failure to document the drug he administered during surgery created an unacceptable risk that Patient EKG would suffer an overdose or that an overdose would go unrecognized.

150. Respondent's conduct as described in paragraphs 147-149 constitutes unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(16), by violating any provision of Wis. Ch. 447, or any valid rule of the board.

151. Based upon the above findings of fact contained in paragraphs 1 through 150, there is probable cause to find that the public health, safety or welfare imperatively requires emergency suspension of the Respondent's license.

CONCLUSIONS OF LAW

1. Sufficient notice of this proceeding has been given to Respondent Jeffrey J. Becker, D.D.S., as required by Wis. Admin. Code § SPS 6.05.

2. The Dentistry Examining Board is authorized, pursuant to Wis. Sta. §§ 227.51(3), 447.07(3), and Wis. Admin. Code § SPS 6.06, to summarily suspend Respondent's license to practice dentistry in the state of Wisconsin upon probable cause to believe that Respondent violated the provisions of chapter 447, Wisconsin Statutes; and probable cause to believe that the public health, safety, or welfare imperatively requires emergency action.

3. There is probable cause to believe that Jeffrey J. Becker, D.D.S., has engaged in unprofessional conduct as defined by Wis. Admin. Code §§ DE 5.02(1), (15), (16), (18) and Wis. Stat. § 447.07(3)(a), as described in Counts I - XXVIII, above.

4. There is probable cause to believe that Jeffrey J. Becker, D.D.S.'s, practice fell below the standard of minimal competence in the profession of dentistry pursuant to Wis. Admin. Code § DE 11.09(3), as described in Counts XVII and XXVIII, above.

6. There is probable cause to believe that Jeffrey J. Becker, D.D.S., engaged in conduct that which indicates a lack of knowledge, an inability to apply or the negligent application of principles or skills of dentistry pursuant to Wis. Stat. 447.07(3)(h), as described in Counts VI-VIII, XI, XIII-XVII, XX, XXII, XXIV, and XXVII.

7. To protect the public's health, safety and welfare, it is necessary to immediately suspend Respondent's license to practice dentistry in the State of Wisconsin.

ORDER

1. The license to practice dentistry in the state of Wisconsin of Jeffrey J. Becker, D.D.S., is SUMMARILY SUSPENDED until the effective date of a Final Decision and Order issued in the Disciplinary Proceeding against Respondent Jeffrey J. Becker, D.D.S., unless otherwise ordered by the Board.

2. A formal Complaint shall, if not already, be filed with the Division of Hearings and Appeals, alleging that Respondent has committed unprofessional conduct.

3. Respondent Jeffrey J. Becker, D.D.S., is hereby notified of his right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause as to why this summary suspension order should not be continued. Respondent is further notified that any request for a hearing to show cause should be filed with the Wisconsin Dentistry Examining Board, P.O. Box 8366, Madison, Wisconsin 53708-8366.

4. In the event that Respondent Jeffrey J. Becker, D.D.S., requests a hearing to show cause as to why the Summary Suspension should not be continued, that hearing shall be

scheduled to be heard on a date within twenty (20) days of receipt by the Board of Respondent's request for a hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN DENTISTRY EXAMINING BOARD

By: _____ 8/6/2014
Attorney Chad Zadrazil, Date
On Behalf of the Dentistry
Examining Board