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Before the
State Of Wisconsin
Dentistry Examining Board

In the Matter of the Disciplinary Proceedings
Against Elisabeth M. Baertlein, D.M.D.,
Respondent.

FINAL DECISION AND ORDER
ORDER 0008325
Order No. _____

Division of Legal Services and Compliance Case No. 19 DEN 107

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, make 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 at Madison, Wisconsin on the 04th day of January, 2022.

Member
Dentistry Examining Board

Before the
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against Elisabeth M. Baertlein, D.M.D., Respondent.	DHA Case No. SPS-22-0005 DLSC Case No. 19 DEN 107

PROPOSED DECISION AND ORDER

The PARTIES to this proceeding are:

Elisabeth M. Baertlein, by
Attorney Richard H. Lehman
Richard H. Lehman Law
53 W. Jackson Blvd., Ste. 950
Chicago, IL 60604

Department of Safety and Professional Services,
Division of Legal Services and Compliance, by
Attorney Nicholas Dalla Santa
P.O. Box 7190
Madison, WI 53707-7190

PRELIMINARY RECITALS

On January 25, 2022, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division) filed a Complaint and Notice of Hearing alleging that the Respondent Elisabeth M. Baertlein, D.M.D. is subject to discipline by the Dentistry Examining Board (Board) for engaging in violations related to her Wisconsin license to practice dentistry. The matter was referred to the Division of Hearings and Appeals for hearing, and Administrative Law Judge Andrea Brauer was appointed to preside over a Class II hearing. Judge Brauer conducted a telephone prehearing conference with the parties on March 3, 2022, at which time the issues for hearing were confirmed, a scheduling order was established, and a hearing was scheduled.

Pursuant to due notice and agreement by the parties, a hearing was held on August 16 and 17, 2022 in Madison, Wisconsin. The hearing was recorded by stenographer. Dr. Baertlein appeared by Attorney Richard H. Lehman, and the Division appeared by Attorney Nicholas Dalla Santa. Testimony was heard from Dr. Baertlein, Dr. Megan Wolfinger, Dr. Lyndsay Knoell, and Dr. Ahmad Eslami. The record includes the hearing transcript, the Division's Exhibits 1–7 and 10–15, and Dr. Baertlein's Exhibits 100–107 and 110.[1] The parties also submitted post-hearing briefs on the issue of discipline and costs.

[1] For purposes of clarity, testifying witnesses were allowed to refer to exhibits as they were marked during pre-hearing depositions. Accordingly, when witnesses referred to exhibits A-D, they were referring to the corresponding

FINDINGS OF FACT

1. Respondent Elisabeth M. Baertlein, D.M.D., (DOB: June 28, 1964) is licensed in the state of Wisconsin to practice dentistry, having license number 6625-15, first issued on October 12, 2010, and current through September 23, 2023. She has practiced as a dentist since 2004. (Answer ¶1; Baertlein testimony tr. at p. 8-9)

2. Beginning on approximately July 5, 2018, and ending on September 26, 2018, Dr. Baertlein was employed as a locum tenens dentist at Midwest Dental in Sherwood, Wisconsin. During that time, she filled in for Dr. Megan Wolfinger, the owner of Midwest Dental, who was out of the office on maternity leave. (Baertlein testimony tr. at p. 43-46, 282-284)

3. While working at Midwest Dental, Dr. Baertlein treated a patient, S.K., at dental appointments on August 29, September 12, and September 26, 2018. S.K. has been Dr. Wolfinger's patient since approximately November of 2017. (Baertlein testimony tr. at p. 104; Wolfinger testimony tr. at p. 42)

4. S.K. has a history of dental issues, including the following. When Dr. Baertlein first saw S.K., S.K. was missing tooth #14 and had crowns on teeth #13 and 18. The crown on tooth #18 was chipped and had open margins. Tooth #18 also had a previous root canal. In addition, Dr. Wolfinger's patient notes from March 8, 2018, documented a crack on tooth #12 which was being monitored. (Wolfinger testimony tr. at p. 46, 68-70, 87-90; Ex. 2, p. 11)

5. At the August 29, 2018 appointment, S.K. presented with pain while biting on teeth #18 and #19, and stated she felt a "zinger" when biting on tooth #18 a few days prior. Dr. Baertlein adjusted S.K.'s bite and took an x-ray of tooth #18 (Ex. 102, p. 24). She then advised that a new crown be placed on tooth #18 and a four-crown bridge be placed on teeth #12 to 15. (Answer ¶8; Ex. 2, p. 15)

6. At the September 12, 2018 appointment, Dr. Baertlein removed the existing crowns and build-ups on teeth #13 and 18. She then placed a temporary crown on tooth #18 and a temporary bridge on teeth #12 to 15 in preparation for the permanent restorations. She also placed a small filling on tooth #11. No x-rays were taken. (Answer ¶9; Ex. 2, p. 16; Baertlein testimony tr. at p. 121-124)

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exhibit numbers, as follows: Exhibits 1, 100, and A are identical; Exhibits 2, 101, and B are identical; Exhibits 3, 102, and C are mostly identical; and Exhibits 4, 103, and D are identical. The Division indicated that the labels on its Exhibit 3 were misprinted, and requested I rely on Exhibit 102 instead. (Tr. at p. 99-100)

7. At the September 26, 2018 appointment, Dr. Baertlein removed the temporary fixtures and seated the permanent bridge on teeth #12 to 15 and a permanent crown on tooth #18 (Answer ¶10; Ex. 2, p.16; Baertlein testimony tr. at p.121-124). She took two bitewing x-rays which included tooth #18 (Ex. 102, p. 25-26) and two periapical x-rays showing teeth #12 to 15 (Ex. 2, p. 17). Additional x-rays may have been taken but were not noted in the patient notes.

8. With regard to the seating of the permanent crown on tooth #18:

    a. Because part of tooth #18 was missing, Dr. Baertlein built up the tooth's core with filler material before placing the crown. A bitewing x-ray was taken, which showed open margins and that adjustments were needed because the crown was not seating all the way down on the tooth. Dr. Baertlein then adjusted the crown on tooth #18 and cemented it in place.

    b. The x-ray images taken by Dr. Baertlein on the day of the procedure show that the mesial margin of the crown was seated on filler material rather than tooth structure. There was also a ledge below the distal margin. (Knoell testimony tr. at p. 205-211)

    c. Dr. Baertlein noted the ledge in her patient notes. She also informed S.K. that the ledge could be smoothed at a follow-up appointment and instructed S.K. to return if it caused any problems. (Ex. 2, p.17; Baertlein testimony tr. at p. 146)

9. On November 27, 2018, S.K. was seen by Dr. Wolfinger. Prior to the appointment, S.K. had called Midwest Dental over the course of several days complaining of pain and requesting to be seen. At the appointment, Dr. Wolfinger diagnosed S.K. with a periapical abscess on teeth #12 and 18. Dr. Wolfinger took a periapical x-ray of the upper left (Ex. 102, p. 28) and a bitewing x-ray which again showed the crown on tooth #18 seated on filler material with a ledge on the distal margin (Ex. 102, p. 27). Dr. Wolfinger also noted there was a fistula on tooth #12 and a gap on tooth #18 where food was getting stuck. S.K. was referred to an endodontist for root canal treatment of tooth #12 and either retreatment or extraction of tooth #18. (Wolfinger testimony tr. at p. 49-53 and 72-73; Ex 2, p. 18)

10. On January 28, 2019, an endodontist began root canal treatment of tooth #12, but the root canal was not completed because the tooth was fractured. Extraction of tooth #12 was advised. X-rays were also taken of tooth #18 showing a defect in the mesial root, including radiolucency. The endodontist recommended that tooth #18 be kept under observation and noted that tooth #18 may eventually need to be extracted. (Ex. 4, p. 9-16)

11. On February 19, 2019, Tooth #12 was extracted. (Ex. 2, p. 20)

12. On October 1, 2019, S.K. returned to see Dr. Wolfinger complaining of lower left pain. X-rays were taken and showed a vertical fracture in the mesial root of tooth #18. Extraction of tooth #18 was advised. (Ex. 2, p. 23; Ex. 102, p. 37-38)

13. On October 3, 2019, tooth #18 was extracted. (Ex. 2, p. 24)

14. The fracture in tooth #18 is the reason the tooth had to be extracted and occurred because the crown was not properly placed by Dr. Baertlein.

15. On January 25, 2022, the Division filed a complaint against Dr. Baertlein's license requesting discipline and costs for allegedly engaging in unprofessional conduct by practicing in a manner that substantially departed from the standard of care ordinarily exercised by a dentist which harmed or could have harmed patient S.K.

16. On February 14, 2022, Dr. Baertlein timely answered.

DISCUSSION

In order to recommend discipline, I must find the Division has proven by a preponderance of the credible evidence that Dr. Baertlein engaged in unprofessional conduct pursuant to Wis. Admin. Code § DE 5.02(5) by practicing in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which harmed or could have harmed a patient. If so, she is subject to discipline pursuant to Wis. Stat. § 447.07(3)(a) and (f) for engaging in unprofessional conduct, violating the standards of conduct established by the Board, and violating a rule related to the practice of dentistry. *See* Wis. Admin. Code § HA 1.17(2).

I find the Division has met its burden with regard to the treatment of tooth #18 but not the treatment of teeth #12 to 15. I recommend that Dr. Baertlein be reprimanded, ordered to complete seven hours of education, and assessed two-thirds of the costs of the proceeding as specified in the proposed order below.

Standard of Care Violation

Tooth #18

The Division alleges that the permanent crown placed on tooth #18 violated Wis. Admin. Code § DE 5.02(5) for the following two reasons: (1) part of the crown was seated on filler material rather than tooth structure; and (2) an impermissible ledge was left between the tooth margin and the crown. These will be addressed in turn, below, showing that the record supports the Division's position.

It is undisputed that the standard of care requires a crown to be placed on tooth structure, and that it is incorrect for a crown to end on filler material. This is because if the crown does not end on solid tooth, there could be seepage under the crown, which could cause the core to break

down and the tooth to decay. In addition, because S.K. had a prior root canal in tooth #18, S.K. would not feel pain in the area and the issue could go unaddressed causing the root to split. (Baertlein testimony tr. at p. 172-174)

Dr. Baertlein's position is that the crown she placed did end on solid tooth structure but must have moved thereafter. This directly conflicts with the x-rays in the file from the day of the procedure that show otherwise. Accordingly, she contends that the x-rays in the file showing the ill-fitting crown are not the x-rays she took of S.K. and must have been taken at a later date. She maintains that the crown must have moved across the tooth after she placed it due to S.K.'s history of bruxing and grinding, which she believes is also likely what caused the tooth to crack. In support of her argument, she points to certain discrepancies in S.K.'s patient records. For example, Dr. Baertlein's patient notes for September 26, 2018 document that a bitewing x-ray and two periapical x-rays were taken, but the file contains two bitewing x-rays for that date. Dr. Baertlein further claims that she actually would have taken at least five x-rays at the September 26, 2018 appointment but not documented all of them in the patient notes. She also states that she adds notes to her x-rays to identify the x-ray type and date, but the images on file with Midwest Dental contain no labels or notes. Instead, the labels on the x-rays submitted for purposes of this hearing were added by the Division based on its discussion with Dr. Wolfinger about the records on file.

While I agree that the periapical x-rays from September 26, 2018 appear to be missing, the evidence does not establish that the remaining records in the file are inaccurate. Dr. Wolfinger testified that she provided a complete copy of S.K.'s patient file, and that the dates of the x-ray images have been correctly identified based on the date listed within Midwest Dental's electronic records management system (Wolfinger testimony tr. at p. 58-63, 66). Any assertion that records in S.K.'s file were modified or incorrectly identified by Midwest Dental is purely speculative and unconvincing.

Further, I find that the bitewing x-rays from September 26, 2018 are an accurate representation of how S.K.'s teeth would have appeared on that date. They show the four-crown bridge on teeth #12 to 15 and the crown on #18 with a ledge on the distal margin. The bitewing x-ray Dr. Wolfinger took on November 27, 2018 looks similar as well. The Division's expert, Dr. Lyndsay Knoell, testified that bruxing and grinding would not cause a crown to move across a tooth. Because the crown is cemented, it would either stay in place or fall of the tooth completely (Knoell testimony tr. at p. 214-215). The Respondent's expert, Dr. Ahmad Eslami, generally agreed but stated that it would be possible for a crown to shift on the top of the tooth if there was a fracture in the tooth's root because the fracture could cause the tooth's core to become unstable and shift. However, this scenario does not apply, because the x-rays from September 26, 2018 show the crown placed on filler material before the root in tooth #18 became fractured. (Eslami testimony tr. at p. 352-354 and 358-359) Therefore, I am unpersuaded by Dr. Baertlein's assertion that the x-ray images in Midwest Dental's file are not the x-rays she took of S.K. on that date.

Having concluded that the x-rays at issue are the images of S.K. taken by Dr. Baertlein on September 26, 2018, it is undisputed that the standard of care was violated. Dr. Baertlein

stated of the images "Absolutely not. It's not standard of care" because there is an open mesial margin, an open lingual margin, and the margin is sitting on core material (Baertlein testimony tr. at p.174). Both Dr. Knoell and Dr. Eslami agreed that the treatment was not standard of care because the crown should rest entirely on natural tooth. Dr. Knoell further explained that when a crown is placed on a tooth with a prior root canal, the crown must attach to one to two millimeters of tooth on all sides for the tooth to sufficiently strong and not to split. Dr. Knoell expected based on the crown's placement that either the crown would fall off the tooth or the tooth would split. (Ex. 11, p.3; Knoell testimony tr. at p. 203-207) Ultimately, the tooth's root fractured, and it had to be extracted.

Turning to the ledge, Dr. Baertlein disputes the Division's allegation that she also violated the standard of care by leaving a ledge on the margin of the crown. Both expert witnesses agreed that a ledge on a crown's margin can cause food impaction, which can cause the tooth to decay. The experts also agreed that if a ledge is discovered after the crown is cemented, the appropriate treatment would be to smooth the ledge with a burr. In Dr. Eslami's opinion, the ledge could either be smoothed right away or on a later date if the patient prefers and the dentist adequately discusses follow-up care with the patient (Eslami testimony tr. at p. 350-351). Dr. Knoell testified that in S.K.'s case, standard of care required that the ledge be smoothed immediately at the September 26, 2018 appointment. He concluded that there was no sufficient reason to justify leaving the ledge in place because of the risk of damage to the tooth (Ex. 11, p. 3; Knoell testimony tr. at p. 213-214, 263-264). I find Dr. Knoell's testimony more credible and conclude that by leaving the ledge in place, Dr. Baertlein violated the standard of care and put tooth #18 at risk of decay due to food impaction. At the time of the November 27, 2018 appointment, food was already getting stuck below the ledge and beginning to damage the tooth. (Ex. 2, p. 18; Dr. Knoell testimony tr. at p. 161-162)

Dr. Baertlein's departure from the standard of care in the dual manner described above was substantial and caused harm to S.K. Even Dr. Baertlein agrees that placing a crown on filler material is "absolutely not" standard of care. Adding in her decision to not smooth the ledge right away, there is no question that her errors in treatment were substantial. The evidence is also clear that either of these errors could have caused tooth #18 to fail. Dr. Baertlein's violation of the standard of care is what ultimately caused S.K. to lose tooth #18. Both experts agreed that if a crown is placed on filler material, it is likely that the tooth will decay and may crack. The experts also agreed that leaving a ledge on a crown's margin can also cause the tooth to decay due to food impaction. This is exactly what happened to S.K. The patient harm was as expected based on the errors in treatment.

Therefore, Dr. Baertlein's treatment of tooth #18 substantially departed from the standard of care ordinarily exercised by a dentist which harmed the patient and constitutes a violation of Wis. Admin. Code § DE 5.02(5).

Teeth #12 to 15

The Division also argues that Dr. Baertlein's placement of the four-crown bridge on teeth #12 to 15 substantially departed from the standard of care because she did not take adequate x-

rays showing the status of tooth #12 leading up to the procedure despite the crack previously noted by Dr. Wolfinger. The Division also alleges generally that Dr. Baertlein did not adequately plan for the procedure or sufficiently document the treatment. However, as explained above, I find that Dr. Baertlein took two periapical x-rays showing teeth #12 to 15 at the September 26, 2018 appointment while placing the permanent bridge but these x-rays are missing from the file. More importantly, neither expert witness concluded that the treatment of teeth #12 to 15 was below standard of care. Dr. Knoell stated that it would have been prudent for Dr. Baertlein to take an additional x-ray of tooth #12 before placing the bridge, and to include a note in the patient file documenting that she discussed the status of tooth #12 before placing the bridge. However, Dr. Knoell concluded that it is not clear that Dr. Baertlein's treatment or judgment fell below the standard of care (Knoell testimony tr. at p. 191-196; Ex. 11, p. 5). Dr. Eslami further concluded that Dr. Baertlein's judgment was sound because the tooth was asymptomatic, and dentists are generally expected to take fewer x-rays, if possible, to minimize patients' exposure to radiation (Eslami testimony tr. at p. 336-341).

Because neither expert concluded that the treatment of teeth #12 to 15 was below the standard of care, the Division has not met its burden with regard to this procedure. It is therefore not a valid basis for discipline.

Discipline

The Board is authorized to discipline Dr. Baertlein pursuant to Wis. Stat. § 447.07(3)(a) and (f) for engaging in unprofessional conduct, violating the standards of conduct established by the Board, and violating a rule related to the practice of dentistry. The statute authorizes the Board to deny, limit, suspend, or revoke the license depending on the severity of the violations.

The Division requests that Dr. Baertlein be reprimanded and required to complete 13 hours of education in the following topics: three hours on recordkeeping, three hours on informed consent, three hours on treatment planning, and four hours of hands-on education on standard of care and best practices for fixed prosthodontics. I agree that a reprimand and education is appropriate. However, any required education should be responsive to the violation proven. I am therefore recommending that Dr. Baertlein be reprimanded and required to complete seven hours of education, comprised of three hours on treatment planning and four hours of hands-on education on standard of care and best practices for fixed prosthodontics, under terms specified in the proposed order below.

The purposes of discipline are: (1) to promote the rehabilitation of the credential holder; (2) to protect the public from other instances of misconduct; and (3) to deter other credential holders from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976). Courts have also stated that "Protection of the public is the purpose of requiring a license." *State ex rel. Green v. Clark*, 235 Wis. 628, 631, 294 N.W. 25 (1940). When a license is granted to an individual, Wisconsin is assuring the public that the licensed individual is competent in his or her profession. *Stringez v. Dep't of Regulation & Licensing Dentistry Examining Bd.*, 103 Wis. 2d 281, 287, 307 N.W.2d 664 (1981).

The proposed discipline is consistent with the purposes of discipline and prior Board decisions. It promotes rehabilitation by ordering education to address the deficiencies in Dr. Baertlein's practice and her ability to meet the standard of care related to preparing and placing fixed prosthodontics. The Division stated that its primary concern is Dr. Baertlein's technical skills in placing the crown. (Division's Brief re Discipline p. 2) The proposed discipline also protects the public from other misconduct. A licensee who violates the standard of care must be held accountable, and the public has a right to be aware of that violation. A public reprimand ensures that the Respondent's potential employers, business partners, and patients are able to determine whether the violations in this case raise any concerns when deciding to hire, work with, or seek care from the Respondent. Further, the proposed discipline deters other credential holders from engaging in similar conduct. The public nature of a reprimand serves as notice to other licensees that the conduct in this case violates the standard of care and results in formal discipline. Licensees are required to be aware of the standard of care and should be aware of the potential consequences of violating it. Imposing anything less than a reprimand could imply that such substandard care by a licensee is tolerable.

Finally, the proposed discipline is consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Richard J. Grzybowski*, Order Number 0007871 (March 2, 2022) (dentist reprimanded and ordered to complete education on inadequate documentation, including the failure to document that he reviewed and compared x-rays);[2] *In the Matter of Disciplinary Proceedings Against Steven W. Campbell*, Order Number 0007870 (March 2, 2022) (dentist reprimanded and ordered to complete education for failing to meet the standard of care by not maintaining complete patient records and failing to take bitewing x-rays);[3] *In the Matter of Disciplinary Proceedings Against Michael C. Fisher*, Order Number 0007461 (July 7, 2021) (dentist's license suspended for six months and ordered to complete education for failing to meet the standard of care by not reviewing prior x-rays, not developing a treatment plan and discussing it with the patient, and for placing a crown without first addressing decay on a tooth).[4]

Based upon the facts of this case and the factors set forth in *Aldrich*, issuing a reprimand and ordering continuing education, pursuant to the terms and conditions of the Order below, is reasonable and warranted.

Assessment of Costs

The Division requests that Dr. Baertlein be assessed the full costs of these proceedings. Assessment of costs is appropriate in this case pursuant to Wis. Stat. § 440.22(2) because a reprimand and license limitation are recommended. The Board is vested with discretion concerning whether to assess all or part of the costs of this proceeding based on the aggravating and mitigating facts of the case. *Noesen v. State Department of Regulation & Licensing,*

[2] In the Matter of the Disciplinary Proceedings Against Richard J. Grzybowski, D.D.S., Order Number 0007871
[3] In the Matter of the Disciplinary Proceedings Against Steven W. Campbell, D.D.S., Order Number 0007870
[4] In the Matter of the Disciplinary Proceedings Against Michael C. Fisher, D.D.S., Order Number 0007461

Pharmacy Examining Board, 2008 WI App 52, ¶¶ 30-32, 311 Wis. 2d. 237, 751 N.W.2d 385. In previous orders, Boards have considered the following factors when determining if all or part of the costs should be assessed against a licensee: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the licensee's cooperation with the disciplinary process; (5) prior discipline, if any; (6) the fact that the Department is a program revenue agency, funded by other licensees; and (7) any other relevant circumstances. *See In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008).

Here, it is appropriate to assess two-thirds of the costs of the proceeding against Dr. Baertlein. Full costs are not warranted because the Division has proven only one of its two alleged bases for discipline. It is, however, appropriate to assess more than half of the costs of the proceeding against Dr. Baertlein. The proven violation is serious, as the treatment was clearly below the standard of care and caused significant patient harm, ultimately causing S.K. to lose a tooth. Even if the Division had only moved forward to hearing on the violation proven, there still would have been a lengthy investigation and discovery process, likely including depositions of all four witnesses. The Department is a program revenue agency whose operating costs are funded by the revenue received from credential holders. It would be unfair to impose the costs of pursuing discipline in this matter on those licensees who have not engaged in misconduct. Therefore, it is appropriate for Dr. Baertlein to pay two-thirds of the costs of the investigation and this proceeding, as determined pursuant to Wis. Admin. Code § SPS 2.18.

CONCLUSIONS OF LAW

1. The Division has the burden to prove its allegations by a preponderance of the credible evidence. Wis. Admin. Code §§ HA 1.12(3)(b) and 1.17(2).

2. With regard to the crown placement on tooth #18, Dr. Baertlein engaged in unprofessional conduct pursuant to Wis. Admin. Code § DE 5.02(5) by practicing in a manner which substantially departed from the standard of care ordinarily exercised by a dentist which harmed or could have harmed a patient.

3. Dr. Baertlein is therefore subject to discipline pursuant to Wis. Stat. § 447.07(3)(a) and (f) for engaging in unprofessional conduct, violating the standards of conduct established by the Board, and violating a rule related to the practice of dentistry.

4. The placement of the four-crown bridge on teeth #12 to 15 did not constitute a violation of the standard of care or any standard related to the practice of dentistry. It is therefore not a valid basis for discipline.

5. Under the standards for discipline articulated in *Aldrich*, the below discipline is warranted based on the violation the Division has proven.

6. Pursuant to Wis. Stat. § 440.22, it is appropriate to assess two-thirds of the costs of the proceeding against Dr. Baertlein based on the violation proven.

7. This hearing examiner has authority to issue this proposed decision and order pursuant to Wis. Admin. Code § SPS 2.10 and Wis. Stat. § 227.46.

PROPOSED ORDER

For the reasons set forth above, IT IS ORDERED:

1. Respondent Elisabeth M. Baertlein, D.M.D., is REPRIMANDED.

2. The license to practice dentistry issued to Respondent (license number 6625-15) is LIMITED as follows:

   a. Within 90 days of the date of this Order, Respondent shall successfully complete three hours of education on the topic of treatment planning and four hours of education on the topic of basic standards of care and best practices for fixed prosthodontics offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

   b. All education completed pursuant to this Order shall be taken in-person. Any deviation from in-person education must first be preapproved by the Board's monitoring liaison.

   c. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

   d. Respondent shall submit proof of successful completion of the ordered education in the form of verification from the institution providing the education to the Department Monitor at the address stated below.

   e. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.

   f. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.

3. In the event Respondent violates any term of this Order, Respondent's license (No. 6625-15), or the right to renew her license, may, in the discretion of the Board or its designee,

be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

4. Respondent shall pay two-thirds of the recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § SPS 2.18.

5. Petitions, payment of costs (made payable to the Department of Safety and Professional Services), and any other questions or submissions related to this Order, may be directed to the Department Monitor at:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Respondent may also submit this information online at: https://dspsmonitoring.wi.gov.

6. The terms of this Order are effective on the date the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin on November 18, 2022.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
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By: Andrea Brauer
Andrea Brauer
Administrative Law Judge