STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,)
BOARD OF DENTISTRY,)
)
Petitioner,)
)
vs.) Case No. 99-4690
)
DOUGLAS J. PHILLIPS, D.D.S.,)
)
Respondent.)
______________________________)

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on October 16-18, 2000, and January 22-24, 2001, at West Palm Beach, Florida, before Claude B. Arrington, a duly-designated Administrative Law Judge of the Division of Administrative Hearings. The record closed in this proceeding when the parties completed a rebuttal deposition on April 6, 2001.

APPEARANCES

For Petitioner: Rosanna Catalano, Esquire
R. Lynn Lovejoy, Esquire
Agency for Health Care Administration
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For Respondent: James M. Tuthill, Esquire
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STATEMENT OF THE ISSUE

Whether Respondent, a licensed dentist, committed the offenses alleged in the First Amended Administrative Complaint and the penalties, if any, that should be imposed.

PRELIMINARY STATEMENT

Petitioner filed an Administrative Complaint against Respondent based on his diagnosis and treatment of a patient who will be referred to as C. C. Respondent denied the alleged violations set forth in the Administrative Complaint and demanded a formal administrative hearing. The matter was referred to the Division of Administrative Hearings, and this proceeding followed.

Thereafter, Petitioner's motion for leave to amend its administrative complaint was granted. Petitioner's First Amended Administrative Complaint, dated May 24, 2000, and filed with the Division of Administrative Hearings on June 15, 2000, alleged certain facts pertaining to Respondent's diagnosis and treatment of C. C. Based on those allegations, Petitioner charged Respondent with the following violations: 1/

> COUNT I: Violating Section 466.028(1)(m), Florida Statutes, by failing to keep adequate dental records.
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> COUNT II: Violating Section 466.028(1)(t), Florida Statutes, by committing fraud, deceit, or misconduct in the practice of dentistry.

COUNT III: Violating Section 466.624(1)(w), Florida Statutes, by experimenting on a patient without the patient's informed, written consent.

COUNT IV: Violating Rule 64B5-17.011, Florida Administrative Code, by failing to maintain malpractice insurance or other proof of financial responsibility.

COUNT V: Violating Section 455.624(1)(o), Florida Statutes, by performing professional services that had not been authorized by his patient in violation of Section 766.103, Florida Statutes.

COUNT VI: Violating Section 466.028(1)(x), Florida Statutes, by practicing below the standard of care.

At the final hearing, the parties offered four joint exhibits, each of which was admitted into evidence.

Petitioner called the following witnesses for live testimony: AHCA investigator Bonnie Schaffrick; Respondent; Thomas Eugene Shields, D.D.S.; Henry Allen Gremion, D.D.S.; Theresa Anne Dolan, D.D.S.; Gregory Becker, D.D.S.; and Richard Marx, D.D.S. The Petitioner called the following rebuttal witnesses for live testimony: Richard Chichetti, D.M.D.; and Robert Baratz, M.D., D.D.S., Ph.D. In addition to the joint exhibits, Petitioner offered 24 exhibits, each of which was admitted into evidence. Among Petitioner's exhibits were the depositions of the following: C. C. (transcript and video); Dr. Chichetti (transcript and video); Parker Mahan, D.D.S.

(transcript and video); Stewart Kline, M.D. (transcript only); and Dr. Baratz (transcript only).

Respondent testified at the final hearing and presented the additional testimony of Douglas Martin, M.D.; Rupert Bliss, D.D.S.; and Dietrich Klinghardt, M.D., Ph.D. In addition to the joint exhibits, Respondent offered 39 exhibits. Respondent's Exhibits 10, 13, 14, 15, and 18 were rejected. Respondent's Exhibit 16 was withdrawn. All other Respondent's exhibits were admitted into evidence. Respondent's exhibits included the depositions (transcript and video for each deponent) of the following: Boyd Haley, Ph.D.; Donald Warren, D.D.S.; Jerry E. Bouquot, D.D.S.; Raymond G. Behm, D.D.S.; Wesley Shankland, D.D.S., Ph.D.; Richard T. Hansen, D.M.D.; Christopher J. Hussar, D.D.S., M.D.; Marlind H. Stiles, D.M.D.; David Minkoff, M.D.; James P. Carter, Sr., M.D.; William Cowden, M.D.; Mark McClure, D.D.S.; James Medlock, D.D.S.; Andrew Slavin, D.D.S.; and Victor A. Marcial-Vega, M.D.

The parties made extensive objections to the depositions entered into evidence. Motion hearings were held January 4, 2001, February 9, 2001, February 23, 2001, and March 28, 2001. Transcripts of those motion hearings are part of the record. Additionally, the undersigned entered separate orders ruling on those objections not ruled upon during the motion hearings.

Transcripts of the proceedings conducted on October 16, 2000, consisting of Volumes I and II, were filed on April 25, 2001. Transcripts of the proceedings conducted on October 17 and 18, 2000, consisting of Volumes III-VI, were filed April 24, 2001. Transcripts of the proceedings conducted on January 22-24, 2001, consisting of Volumes I-V, were filed February 23, 2001. Each party filed a Proposed Recommended Order, which has been duly considered by the undersigned in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner is a state agency charged with regulating the practice of dentistry pursuant to Section 20.43, Florida Statutes, and Chapters 455 and 466, Florida Statutes.

2. Pursuant to the authority of Section 20.43 (3)(g), Florida Statutes, Petitioner has contracted with the Agency for Health Care Administration to prosecute administrative complaints as required by the Board of Dentistry.

3. Respondent is, and has been since 1966, a licensed dentist in the State of Florida, having been issued license number DN 0004148. At the time of the final hearing, Respondent’s office address was 4512 Flagler Drive, #301, West Palm Beach, Florida 33407-3802. One prior disciplinary proceeding has been filed against Respondent's license. The

record is silent as to the details of that prior disciplinary action.

4. In addition to a traditional general dental practice, Respondent practices alternative dentistry (also referred to by Respondent as biological dentistry) on chronically ill patients. In his alternative dental practice, Respondent utilizes unconventional diagnostic methodologies and homeopathic remedies.

5. In December 1995 and January 1996, Respondent treated C. C., a female born May 10, 1950.

6. At the times pertinent to this proceeding, C. C. considered herself to be pre-cancerous and chronically ill. C. C. believed that she had suffered radiation poisoning in 1986 when a cloud from the nuclear disaster at Chernobyl 2/ passed over her home in Italy while she was outside in the garden.

7. C. C., a chiropractor, became interested in alternative dentistry and attended various seminars presented by proponents of alternative medicine and dentistry. C. C. consulted with different health care professionals, including dentists, medical doctors, and nutritionists, and became familiar with alternative dentistry and homeopathic remedies. C. C. believed that the amalgams in her teeth had become toxic and were inhibiting her recovery to full health. At one of these seminars in 1995, C. C. submitted to a test that purportedly revealed she suffered from heavy metal poisoning. She also examined her blood through a

powerful microscope and found her blood to be unusual, which reinforced her belief that she was pre-cancerous.

8. C. C. met Dr. Dietrich Klinghardt at a seminar in 1995 on the topic of alternative dentistry. The seminar attended by Dr. Klinghardt and C. C. included a discussion on toxicity from the oral cavity causing systemic health problems. The seminar also included a discussion on the treatment of dental conditions using homeopathic remedies.

9. C. C. asked Dr. Klinghardt whether he thought she should have her amalgams replaced with non-toxic materials. He recommended that she do so and he also recommended that she have extracted any tooth that had a root canal.

10. C. C. asked Dr. Klinghardt to recommend a dentist to remove her amalgams. Dr. Klinghardt recommended Respondent for the amalgam replacement.

11. Notakehl, Pefrakehl, and Arthrokehlan, the three homeopathic remedies Respondent used in his subsequent treatment of C. C., were discussed at the seminar. These homeopathic remedies are referred to as Sanum remedies, which is a reference to the German manufacturer.

12. In March of 1995, C. C. visited a dentist named Ira Windroff in South Florida. Dr. Windroff took a panoramic X-ray and X-rays of C. C.'s individual teeth. After the X-rays, Dr. Windroff referred C. C. to another dentist, who performed a

root canal on C. C.'s tooth #19, which is in the lower left quadrant.

13. On December 12, 1995, C. C. presented to Respondent's office to discuss having her amalgams replaced.

14. C. C. was experiencing pain in tooth #19 on December 12, 1995. C. C. filled out a standard medical history form that Respondent had used in his practice for several years. C. C. discussed her medical and dental history with Respondent. C. C. told Respondent that she had a root canal on tooth #3 when she was a teenager and that she recently had a root canal on tooth #19. C. C. informed Respondent that she considered herself to be chronically ill and pre-cancerous. She told him she had suffered radiation poisoning in 1986 and preferred to have no unnecessary X-rays. She also told him that she was very weak from a recent bout of the flu.

15. Respondent's office notes reflect that C. C. presented with lower left tooth pain (without identifying a specific tooth) and that he "muscle tested for origin."

16. Respondent purported to evaluate C. C.'s medical and dental status by evaluating whether her autonomic nervous system responded to various stimuli. This form of testing will be referred to as ART, which is an acronym for "Autonomic Response Testing".

17. The autonomic nervous system and ART were explained by several of the experts who testified in this proceeding.

18. The human body has an autonomic nervous system consisting of a sympathetic part and a parasympathetic part. Both parts are regulated by the hypothalamus, which is located deep inside the brain. The nerves constituting the autonomic nervous system pass thorough ganglions, which are groups of nerve cells located outside the brain at different locations of the body that act as relay stations.

19. The sympathetic part of the autonomic nervous system is generally believed to deal with the mechanisms that prepare the body to counteract stresses that come from outside the body. For example, if someone cuts his or her finger, the sympathetic part of the autonomic nervous system will cause blood vessels to contract so the body does not lose all of its blood. It also will prepare the body to fight or flee in response to an outside threat.

20. The parasympathetic part of the autonomic nervous system deals with the body's inner secretions, such as insulin and digestive acids. The reactions of the parasympathetic part of the autonomic nervous system calm the body down after a stress and usually promote healing.

21. Respondent's examination of C. C. on December 12, 1995, lasted between one hour (Respondent's estimate) and three hours (C. C.'s estimate).

22. During part of the ART examination, C. C. reclined in a dental chair. When she was not in the dental chair, she reclined on a massage table.

23. During the ART examination, Respondent used his dental assistant to serve as an indirect tester, which required her to be positioned between the patient and the examiner. The dental assistant held one of C. C.'s hands with one hand while extending her (the dental assistant's) free arm. According to those subscribing to this methodology, the physical contact between the dental assistant and C. C. established an electrical current between them, which caused the responses from C. C.'s autonomic nervous system to be transferred to the dental assistant. Respondent used the dental assistant's deltoid muscle to determine whether a particular stimulus had caused a response from C. C.'s autonomic nervous system. Respondent pushed down on the dental assistant's extended arm after exposing C. C. to a stimulus and evaluated the resistance he encountered. He believed he could determine by that resistance whether the dental assistance's deltoid muscle became weak or remained strong. If the dental assistant's deltoid muscle became weak following C. C.'s exposure to a stimulus, Respondent concluded that the

autonomic nervous system had responded and that the area of the body being tested was not healthy. If the dental assistant's deltoid muscle remained strong, Respondent concluded that the autonomic nervous system had not responded and that the area of the body being tested was healthy.

24. Respondent used his dental assistant as an indirect tester because he considered C. C. to be too weak to be directly tested, which would have required her to extend her arm throughout the examination. 3/

25. After he had C. C. place her hand over her belly button while she was in a reclined position and holding the dental assistant's hand, Respondent pushed down on the dental assistant's extended arm. Based on his evaluation of the resistance in the dental assistant's arm, Respondent believed that C. C.'s autonomic nervous system was in a protective mode. Respondent then attempted to determine the reasons for that finding.

26. Respondent placed vials of various substances, including heavy metals, bacteria from root canal teeth, and homeopathic remedies, on C. C.'s lap to determine whether the substances triggered a response from C. C.'s autonomic nervous system. He placed his fingers on her individual teeth to determine whether that prompted a response from C. C.'s autonomic nervous system. Respondent believed that by ART he could

determine the condition of C. C.'s internal organs, evaluate her dental problems, and identify the homeopathic remedies that would best promote healing.

27. In addition to using ART, Respondent visually inspected C. C.'s teeth with a dental mirror, used a dental explorer to examine the edge of fillings and cracks in the teeth, probed her gums, percussed tooth #19, and palpitated all of her teeth. Although his dental records for this patient do not reflect that he did so and he could not remember having done so prior to C. C.'s deposition, the evidence established that Respondent reviewed the X-rays taken by Dr. Windroff.

28. Respondent did not take any X-ray of tooth #19 before he extracted that tooth. The only X-rays available to Respondent were taken before the root canal was performed on that tooth in March 1995. Respondent also did not order any laboratory tests.

29. Based on his use of ART, Respondent concluded that the following areas of C. C.'s body were compromised: tonsils, heart, spleen, pancreas, liver, gall bladder, large intestines, and pubic. Using ART, Respondent concluded that C. C.'s tooth #3 and tooth #19 had become toxic.

30. Respondent also concluded that the following homeopathic remedies should be used to treat C. C.: Notakehl, Pefrakehl, and Arthrokehlan. Notakehl is a fungal remedy derived from Penicillum chrysogenum. Arthrokehlan is a bacterial remedy

derived from Propionibacterium acnes. Prefakehl is a fungal remedy derived from Candida parapsilosis. 4/

31. Respondent told C. C. that the root canals that had been performed on tooth #3 and tooth #19 contained toxins and were blocking her recovery. He also told her that the removal of her root canal teeth and any toxic area around the root canal teeth should be given higher priority than the replacement of her amalgams.

32. Respondent told C. C. that he could not help her if she did not have her two root canal teeth extracted. Respondent did not offer C. C. any other options because he did not think any other option existed.

33. There was a conflict in the evidence as to whether C. C. consented to the extraction and treatment with the Sanum remedies. That conflict is resolved by finding that Respondent adequately explained to C. C. how he intended to extract the two teeth and what she could expect following the extractions. Although C. C. did not ask to have those two teeth extracted, she clearly agreed to have the extractions. It is further found that C. C. knowingly agreed to Respondent's proposed treatment with the Sanum remedies. C. C. knew about the Sanum remedies and how Respondent was going to use them to treat her.

34. Much of the evidence presented by Respondent related to ART and the manner it was being used by practitioners in December

1995. The undersigned has carefully reviewed and considered that evidence. The undersigned has also reviewed and considered the evidence presented by Petitioner. The following findings are made as to the use of ART in 1995. The Florida Dental Association, the American Medical Association, and the American Dental Association did not recognize ART as a reliable methodology for testing toxic conditions of the teeth. ART was not being taught in any dental school in Florida. ART was not being used by a respected minority of dentists in the United States to the extent it was used by Respondent. Petitioner established by clear and convincing evidence that the extent to which Respondent relied on that methodology in evaluating this patient exceeded any acceptable use of ART in 1995 and constituted practice below the standard of care as alleged in Count VI of the Amended Administrative Complaint. Because of his over-reliance on ART, Respondent's diagnosis was flawed, and there was insufficient justification for his subsequent treatment of the patient. 5/

35. On December 21, 1995, C. C. returned to Respondent for the extraction of tooth #3 and tooth #19. Respondent extracted the two teeth and removed bone in the vicinity of each tooth that he thought was necrotic, a procedure referred to as cavitation. Respondent testified that he encountered soft, mushy bone following the extractions. He removed hard bone in the

extraction area with a small rotary bur. He removed soft tissue and bone with a curette.

36. There was a conflict in the evidence as to whether Respondent was justified in removing bone surrounding the extraction sites. Based on Respondent's testimony and the depositions and dental records of C. C.'s dentists who treated her after Respondent, it is concluded that his decision to remove bone surrounding the extraction sites was within his clinical judgment. It should be noted, however, that Respondent's dental records provide no justification for this extensive removal of bone adjacent to the extraction sites.

37. Following the extractions and cavitation procedures, Respondent injected the patient's mouth and face with Notakehl, Pefrakehl, and Arthrokelan.

38. Prior to her visit to Respondent, C. C.'s teeth #5 and #17 had been extracted. Respondent injected the area where tooth #5 had been with the Sanum remedies using a stabident drill, a dental drill that is usually used to administer anesthesia. He also injected the Sanum remedies where tooth #17 had been. Following the extractions of teeth #3 and #19, Respondent irrigated the extraction wounds with the Sanum remedies. Respondent injected the right sphenopalatine ganglion area and the left and right otic ganglion areas, the superior origin and inferior origin pharyngeal constrictor muscles, and the

submandibular ganglion with a one percent solution of Xylocaine that also contained drops of Notakehl. Respondent testified he used Xylocaine, an epidural grade anesthetic, as a carrier for Notakehl. Some of the injections were made into the oral cavity while others were made through the face. Consistent with homeopathic practice, Respondent believed that these injections would promote healing.

39. Tooth #3 is located directly beneath the right maxillary sinus cavity. From the X-rays available to him, Respondent knew that the root canal material that had been used to fill that tooth was very close to the thin membrane that protects the sinus cavity. Following his extraction of tooth #3, Respondent did not determine whether the maxillary sinus membrane had been perforated during the extraction procedure. Petitioner established by clear and convincing testimony that this failure constituted practice below the standard of care as alleged in Count VI of the Amended Administrative Complaint.

40. Following the extractions, Respondent placed some soft tissue back into the extraction sites, which covered a little bit of the socket, and he left a little bit of an opening for a clot to form to heal from the inside out. He sutured the area around the buccal bone, which he had reflected in order to remove the tooth.

41. C. C. returned to Respondent on December 22, 23, 24, 27, 28, 29, 1995, and January 5 and 10, 1996.

42. On December 22, 1995, Respondent checked the extraction sites and electrically stimulated the extraction sites using a process referred to as micro current.

43. On December 23, 1995, Respondent checked the extraction sites, applied micro current to those sites, and injected a one percent solution of Xylocaine with drops of Notakehl into the right sphenopalatine ganglion, both otic ganglions, and the left submandibular ganglion.

44. On December 24, 1995, Respondent applied micro current to the extraction sites and injected Sanum remedies into the area of the extraction sites.

45. On December 27, 1995, C. C. telephoned Respondent to complain of pain in the area from which tooth #3 had been extracted. From what she told him, Respondent believed that C. C. had a perforated maxillary sinus. When he examined her on December 27, 1995, he confirmed that she had a sinus perforation. Respondent reopened the area he had sutured on December 21, 1995, cleaned out granulated tissue. 6/ He did a flap procedure, referred to as a plastic closure, where tissue was reflected from the cheek side of the gum and placed over the extraction site to the palate side. He thereafter injected the right otic ganglion

and right sphenopalatine ganglion with a solution of one percent Xylocaine and Notakehl.

46. Between December 28, 1995, and January 10, 1996, Respondent continued his homeopathic treatment of C. C. combined with the micro current procedure.

47. Respondent did not treat C. C. after January 10, 1996.

48. C. C. knew when she agreed to the extractions that she would have to have bridges for the areas of the extractions. Those two bridges were inserted after she left Respondent's care.

49. Petitioner asserted that Respondent practiced below the standard of care by failing to appropriately close the sinus perforation on December 27, 1995. That assertion is rejected. On January 18, 1996, James Medlock, D.D.S. examined C. C. at his dental office in West Palm Beach, Florida. C. C. was not experiencing difficulty with the flap procedure Respondent had performed on December 27, 1995, when she was seen by Dr. Medlock. Gary Verigan, D.D.S., treated C. C. at his dental office in California between February 1996 and May 1997. Richard T. Hansen, D.D.S., treated C. C. at his dental office in California between May 1997 and November 1999. The dental records of Dr. Medlock, Dr. Verigan, and Dr. Hansen for C. C. are in evidence as Joint Exhibits 1, 3 and 4, respectively. The depositions of Dr. Medlock and Dr. Hansen are in evidence. Dr. Hansen re-opened the area of the maxillary sinus that

Respondent had closed with the flap procedure and found that bone had not re-generated in that area. Dr. Hansen believed that Respondent was not the cause of the problems for which he treated C. C. There was insufficient evidence to establish that the subsequent dental problems encountered by C. C. were caused by the extraction, cavitation, or flap procedure performed by Respondent in December 1995. Petitioner did not establish by clear and convincing evidence that Respondent's closure of the sinus perforation on December 27, 1995, constituted practice below the standard of care.

50. Respondent did not have malpractice insurance or proof of financial security at the time that he treated C. C. He did not have proof of financial security until March 13, 1997, when he obtained an irrevocable letter of credit from Palm Beach National Bank and Trust to bring himself in compliance with Petitioner's Rule 64B5-17.011, Florida Administrative Code. 7/ This irrevocable letter of credit was current at the time of the final hearing. Respondent is a dentist who treats people who are chronically ill. Respondent's use of ART and homeopathic remedies are clearly unconventional and can, in Respondent's own words, cause a lot of harm if he is not careful. Under the facts of this case, his failure to have malpractice insurance or proof of financial responsibility while practicing alternative dentistry on high-risk patients is found to be an especially

egregious violation of Rule 64B5-17.011, Florida Administrative Code. His subsequent compliance with that Rule is not viewed by the undersigned as being a mitigating factor.

51. Petitioner established by clear and convincing evidence that Respondent failed to keep adequate dental records in violation of Section 466.028(1)(m), Florida Statutes, as alleged in Count II of the Amended Administrative Complaint. Respondent's medical history for the patient is incomplete. Although Respondent testified he did not take X-rays because of the patient's history of radiation poisoning, his medical history does not reflect that history. Respondent did not chart C. C.'s teeth, which is a routine practice. His description of his examination was vague, his findings were vague, and his proposed treatment plan was vague. His records did not reflect that he had viewed X-rays of the patient, did not reflect that Notakehl was injected with Xylocaine, and did not reflect the anesthetic that was used to numb the mouth during the extraction. The most serious deficiency is that his records provide no justification for the extraction of two teeth or for the cavitation procedures that followed, a basic requirement of Section 466.028(1)(m), Florida Statutes.

52. There was a conflict in the evidence as to whether Respondent's use of the Sanum remedies constituted practice below the standard of care or experimentation. Petitioner did not

establish that the practice of homeopathy is per se below the standard of care or that the use of homeopathic remedies in this case constituted experimentation. Respondent established that the three Sanum remedies he administered to C. C. are recognized homeopathic remedies, and he also established that the manner in which he administered these remedies was consistent with homeopathic practice. The conflict in the evidence is resolved by finding that Petitioner did not prove by clear and convincing evidence that Respondent's use of the homeopathic remedies constituted practice below the standard of care or experimentation. 8/

CONCLUSIONS OF LAW

53. The Division of Administrative Hearings has jurisdiction of the parties to and the subject of this proceeding. Section 120.57(1), Florida Statutes.

54. Petitioner has the burden of proving by clear and convincing evidence the allegations against Respondent. See Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112 (Fla. 1st DCA 1989); and Inquiry Concerning a Judge, 645 So. 2d 398 (Fla. 1994). The following statement has been repeatedly cited in discussions of the clear and convincing evidence standard:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief of [sic] conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

55. Section 466.028(1), Florida Statutes, provides, in pertinent part, as follows:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
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> (m) Failing to keep written dental records and medical history records justifying the course of treatment of the patient including, but not limited to, patient histories, examination results, test results, and X rays, if taken.
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> (t) Fraud, deceit, or misconduct in the practice of dentistry or dental hygiene.
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> * * *
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> (x) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, including, but not limited to, the undertaking of diagnosis and treatment for which the dentist is not qualified by training or experience or being guilty of dental malpractice. . . .

56. Petitioner established by clear and convincing evidence that Respondent failed to keep written dental records justifying the course of his treatment of C. C., in violation of Section 466.028 (1)(m), Florida Statutes, as alleged in Count I of the Amended Administrative Complaint.

57. Petitioner alleged in Count II that Respondent was guilty of fraud, deceit, or misconduct in violation of Section 466.028(1)(t), Florida Statutes.

58. Petitioner failed to establish that Respondent engaged in fraud or deceit.

59. Petitioner alleged that Respondent's use of his dental assistant as an indirect tester during the ART evaluation constituted misconduct. Section 466.024(1), Florida Statutes, prohibits a dentist from delegating "irremedial tasks" to a dental hygienist, but permits the dentist to delegate "remedial tasks" to a dental hygienist. As defined by Section 466.003(11) and (12), Florida Statutes, the terms "irremedial tasks" and "remedial tasks" pertain to intraoral treatment tasks performed by a hygienist. The passive role played by the dental hygienist in serving as an indirect tester for ART is not an irremedial task within the meaning of Section 466.024(1), Florida Statutes. Consequently, Petitioner's allegation that Respondent committed

misconduct by using his dental hygienist as an indirect tester is rejected.

60. Any act found to have been committed by Respondent that may be construed to be misconduct related to Respondent's practice below the standard of care, has been appropriately addressed in Count VI. No separate violation of Section 466.028 (1)(t), Florida Statutes, based on the allegations of Count II of the Amended Administrative Complaint, should be found.

61. Petitioner failed to establish that Respondent experimented on C. C. as alleged in Count III of the Amended Administrative Complaint. Any act found to have been committed by Respondent that may be construed to be experimental related to Respondent's practice below the standard of care, has been appropriately addressed in Count VI. Section 455.624(1)(w), Florida Statutes, the provision Petitioner alleged Respondent violated in Count III of Petitioner's Amended Administrative Complaint, does not appear to be applicable to the factual allegations of Count III. Based on the foregoing, it is concluded that no separate violation based on the allegations of Count III of the Amended Administrative Complaint should be found.

62. Petitioner established by clear and convincing evidence that Respondent failed to maintain malpractice insurance or proof of financial responsibility in violation of Rule 64B5-17.011,

Florida Administrative Code, as alleged in Count IV of the Amended Administrative Complaint.

63. Petitioner failed to establish that Respondent performed services on C. C. which had not been duly authorized as alleged in Count V of the Amended Administrative Complaint. Section 455.624(1)(o), Florida Statutes (1999), cited in Count V of Petitioner's Amended Administrative Complaint, does not appear to be an erroneous citation.

64. As set forth in the Findings of Fact, Petitioner established by clear and convincing evidence that Respondent failed to meet the minimum standards of practice in violation of Section 466.028(1)(x), Florida Statutes, as alleged in Count VI of the Amended Administrative Complaint.

65. Rule 64B5-13.005, Florida Administrative Code, provides the following disciplinary guidelines that should be applied to the violations established by Petitioner:

> (1) Unless relevant mitigating factors are demonstrated the Board shall always impose a reprimand and an administrative fine not to exceed $3,000.00 per count or offense when disciplining a licensee for any of the disciplinary grounds listed in subsections (2) or (3) of this rule. The reprimand and administrative fine is in addition to the penalties specified in subsections (2) and (3) for each disciplinary ground.
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> (3) When the Board finds an applicant or licensee whom it regulates under Chapter 466,

Florida Statutes, has committed any of the acts set forth in Section 466.028, Florida Statutes, it shall issue a Final Order imposing appropriate penalties within the ranges recommended in the following disciplinary guidelines:

* * *

(p) Failure to keep written dental records and medical history records justifying the course of treatment of the patient including, but not limited to, patient histories, examination results, test results, and x-rays if taken. The usual action of the Board shall be to impose a period of probation.

* * *

(cc) Being guilty of negligence or dental malpractice. The usual action of the Board shall be to impose a period of probation, restriction of practice, and/or suspension. . . .

* * *

(4) Based upon consideration of aggravating or mitigating factors, present in an individual case, the Board may deviate from the penalties recommended in subsections (2) and (3) above. The Board shall consider as aggravating or mitigating factors the following:

(a) The severity of the offense;

(b) The danger to the public;

(c) The number of repetitions of offenses or number of patients involved;

(d) The length of time since the violation;

(e) The number of times the licensee has been previously disciplined by the Board;

(f) The length of time the licensee has practiced;

(g) The actual damage, physical or otherwise, caused by the violation and the reversibility of the damage;

(h) The deterrent effect of the penalty imposed;
(i) The effect of the penalty upon the licensee's livelihood;
(j) Any efforts of rehabilitation by the licensee;
(k) The actual knowledge of the licensee pertaining to the violation;
(l) Attempts by the licensee to correct or stop the violation or refusal by the licensee to correct or stop violation;
(m) Related violations against the licensee in another state including findings of guilt or innocence, penalties imposed and penalties served;
(n) Penalties imposed for related offenses under sections (2) and (3) above;
(o) Any other relevant mitigating or aggravating factor under the circumstances.
(5) Penalties imposed by the Board pursuant to sections (2) and (3) above may be imposed in combination or individually, and are as follows:
(a) issuance of a reprimand;
(b) imposition of an administrative fine not to exceed $3,000.00 for each count or separate offense;
(c) restriction of the authorized scope of practice;
(d) placement of the licensee on probation for a period of time and subject to such conditions as the Board may specify, including requiring the licensee to attend continuing education courses, to submit to reexamination, or to work under the supervision of another licensee;
(e) suspension of a license;
(f) revocation of a license; however, no license revoked by the Board after December 31, 1987, shall be subject to reinstatement. . . .

66. No aggravating or mitigating factors should be applied to Respondent's failure to keep adequate records (Count I of the Amended Administrative Complaint).

67. As set forth in the Findings of Fact, Respondent's failure to have malpractice insurance or proof of financial responsibility (Count IV of the Amended Administrative Complaint) is viewed as being an egregious violation. Because the guidelines do not specifically address that violation, the recommended penalty contained in this Recommended Order for Count IV is based on the guidelines for violations of similar severity.

68. As set forth in the Findings of Fact, Petitioner established by clear and convincing evidence that Respondent practiced below the standard of care in violation of Section 466.028(1)(x), Florida Statutes (Count VI of the Amended Administrative Complaint). Based on the totality of the record, it is concluded that any arguable aggravating factors have been offset by arguable mitigating factors. Consequently, no aggravating factors or mitigating factors should be applied.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner enter a final order finding Respondent guilty of the violations alleged in Counts I, IV, and VI of the Amended Administrative Complaint. For the violation of Section 466.028(1)(m), Florida Statutes (Count I), Respondent's licensure should be placed on probation for a period of two years with the requirement that he take appropriate continuing education courses pertaining to record-keeping. For

the violation of Rule 64B5-17.011, Florida Administrative Code (Count IV), Respondent's license should be suspended for a period of one year to be followed by a period of probation for a period of five years. For the violation of Section 466.028(1)(x), Florida Statutes (Count VI), Respondent's license should be suspended for a period of one year to be followed by a period of probation for a period of five years. It is further RECOMMENDED that Respondent be reprimanded for each violation and assessed an administrative fine in the amount of $3,000 for each violation, for a total of $9,000. It is further recommended that the suspension of licensure RECOMMENDED for Counts IV and VI and all periods of probation run concurrently. It is further RECOMMENDED that all other charges be dismissed.

DONE AND ENTERED this 15th day of August, 2001, in Tallahassee, Leon County, Florida.

____

CLAUDE B. ARRINGTON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of August, 2001.

ENDNOTES

1/ The following is intended to be a brief summary of the alleged violations. Any question as to the language of the First Amended Administrative Complaint should be resolved by reading that pleading in its entirety.

2/ The Chernobyl disaster occurred April 26, 1986.

3/ Petitioner's argument that Respondent's use of his dental assistant as an indirect tester constituted misconduct is rejected for the reasons set forth in Paragraph 59 of this Recommended Order.

4/ Petitioner referred to these remedies as herbal remedies. That reference is incorrect.

5/ Petitioner also alleged that aspects of Respondent's actual treatment of the patient were below the standard of care or experimental without regard to whether there existed an adequate diagnosis to justify the treatment. The findings and conclusions in the ensuing paragraphs pertaining to Respondent's actual treatment of the patient resolve the conflicting evidence as to those allegations.

6/ Respondent's dental records incorrectly reflect that area #5 was reopened. The evidence established that it was area #3 that was re-treated on December 27, 1995.

7/ Rule 64B5-17.011, Florida Statutes, provides, in part, as follows:

> As a prerequisite for licensure or license renewal every dentist is required to maintain medical malpractice insurance or provide proof of financial responsibility as set forth herein:
> (1) Obtaining and maintaining professional liability coverage in an amount not less than $25,000 per claim, with a minimum annual aggregate of not less than $75,000. . . .
> (2) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, in an amount not less than $25,000 per claim, with a minimum aggregate availability of credit of not less than $75,000. The letter of credit

> shall be payable to the dentist as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the dentist or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, dental care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of the State of Florida or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state.

8/ In making this finding, the undersigned has carefully considered the testimony of Petitioner's experts who, as traditional, allopathic practitioners, clearly believed Respondent should have treated C. C. with traditional antibiotics.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.