

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF)
DENTISTRY,)
)
Petitioner,)
)
vs.) Case No. 04-0079PL
)
JAMES MICHAEL D'AMICO, D.D.S.,)
)
Respondent.)
_____)

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on March 30, 2004, in Orlando, Florida, before Susan B. Kirkland, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Ephraim D. Livingston, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Joseph Harrison, Esquire
Joseph Harrison, P.A.
2500 North Military Trail, Suite 490
Boca Raton, Florida 33431

STATEMENT OF THE ISSUES

Whether Respondent violated Subsections 466.028(1)(m) and 466.028(1)(x), Florida Statutes (1998); Subsections 466.028(1)(i) and 466.028(1)(x), Florida Statutes (2000); and

Subsections 456.072(1)(bb), 466.028(1)(i), 466.028(1)(l), 466.028(1)(m), 466.028(1)(t), and 466.028(1)(x), Florida Statutes (2001), and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On July 22, 2003, Petitioner, Department of Health, Board of Dentistry (Department), filed a 13-count Administrative Complaint against Respondent, James Michael D'Amico, D.D.S. (Dr. D'Amico), alleging that he violated Subsections 466.028(1)(m) and 466.028(1)(x), Florida Statutes (1998); Subsections 466.028(1)(i) and 466.028(1)(x), Florida Statutes (2000); and Subsections 456.072(1)(bb), 466.028(1)(i), 466.028(1)(l), 466.028(1)(m), 466.028(1)(t), and 466.028(1)(x), Florida Statutes (2001). Dr. D'Amico requested an administrative hearing, and the case was forwarded to the Division of Administrative Hearings for assignment to an administrative law judge.

At the final hearing, the Department called the following witnesses: J.H., C.O., and Dr. Edward Allen Rumberger. Petitioner's Exhibits 1 through 12 were admitted in evidence. Petitioner's Exhibit 13 was a late-filed exhibit which is admitted in evidence. The Department presented the testimony of the following witnesses by deposition: A.P., S.P., M.F., Dr. Charles McNamara, Dr. Andre Buchs, Dr. John M. Altomare, Tiffany Callicott, Vickie Bruno, and Lija Scherer.

At the final hearing, Dr. D'Amico testified in his own behalf and presented no exhibits. Dr. D'Amico submitted the late-filed deposition testimony of Dr. Leonard L. Weldon and Dr. Robert E. Marx.

The two-volume Transcript was filed on April 12, 2004. The last late-filed deposition was filed on May 6, 2004. The parties timely submitted proposed recommended orders, which have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. At all material times to this proceeding, Dr. D'Amico was a licensed dentist within the State of Florida, having been issued license number DN 7121.

2. From 1999 to 2000, Dr. D'Amico was practicing dentistry at Florida Dental, located at 1535 Prosperity Farms Road, Lake Park, Florida. Florida Dental was a clinical-type practice, with several general dentists and Dr. D'Amico, who was the oral surgeon.

3. In January 2001, Dr. D'Amico and Dr. Charles McNamara entered into an agreement by which Dr. D'Amico agreed to purchase Dr. McNamara's office equipment and supplies and to sublet Dr. McNamara's office space located on Lakemont Avenue in Winter Park, Florida. Because of an extended illness, Dr. McNamara was no longer going to practice at the Lakemont Avenue office, but was going to work for another dentist. When

Dr. McNamara vacated his office space, he took his patient records with him.

4. Dr. D'Amico was not an independent contractor of Dr. McNamara's, and they did not share a practice. Dr. D'Amico did not leave any of his patients' records with Dr. McNamara. There was not an agreement between Dr. D'Amico and Dr. McNamara that Dr. McNamara would cover for any of Dr. D'Amico's patients.

5. Dr. McNamara had difficulty with Dr. D'Amico paying the rent for the office space and with payments received by Dr. D'Amico from patients of Dr. McNamara. By September 2001, Dr. McNamara was ready to evict Dr. D'Amico from the premises. Dr. McNamara went to the Lakemont Avenue office to give Dr. D'Amico eviction papers, and Dr. D'Amico was not there. A woman was sitting at the reception desk, and it appeared that the practice was being moved. Dr. McNamara later returned to the office, and it was obvious that Dr. D'Amico was no longer practicing at the Lakemont Avenue address.

6. In the fall of 2001, Dr. John M. Altomare was in the process of leaving his office located at 7145 East Colonial Drive, Orlando, Florida, and moving into a new office which was under construction. During the days and hours that Dr. Altomare was not in his East Colonial Drive office, he agreed to let Dr. D'Amico use the office space.

7. Dr. D'Amico had a separate telephone line at the East Colonial Drive office. Dr. D'Amico did not see any of Dr. Altomare's patients at the East Colonial Drive office. Dr. Altomare did not agree to cover for Dr. D'Amico. The relationship between Dr. D'Amico and Dr. Altomare lasted approximately two to three months during the fall of 2001.

8. In the early part of 2002, Dr. D'Amico associated himself with a dental group in Tampa, Florida.

9. Dr. D'Amico failed to publish a notice in the newspaper of greatest circulation in the county where he practiced, advising his patients of the relocation of his practice, when he left Florida Dental and the East Colonial Drive office. The evidence did not establish that the East Colonial Drive office was outside the local telephone directory service of the Lakemont Avenue office.

10. Vicki Bruno was Dr. D'Amico's office manager beginning on August 1, 2001. She filed the patient records and other information in the patients' files. The files were kept in a filing cabinet at the Lakemont Avenue office. When Dr. D'Amico left the Lakemont Avenue office, the files were removed from the office. When Dr. D'Amico starting working out of Dr. Altomare's office, Ms. Bruno was assigned a closet in which to store the files. The closet space was not adequate to store the files,

and, at one time, Ms. Bruno placed the patient files in the trunk of her car.

11. Dr. Edward Allen Rumberger testified as an expert witness for the Department. Dr. Rumberger has been licensed to practice dentistry in Florida since 1975 and is board-certified in oral surgery. He reviewed materials related to the four cases at issue, consisting of patient statements, interviews with other individuals, including a former employee, some of the medical records of the patients, and some of the x-rays related to the cases.

Patient C.O.

12. On June 20, 1999, C.O. needed to have some repair work done on his Hader bar and went to Florida Dental, where he had been treated in the past. C.O. normally dealt with another dentist, but on this particular visit, he was seen by Dr. D'Amico.

13. C.O. had four implants in his upper mouth. Dr. D'Amico advised C.O. that he did not have enough support for the implants and that he needed to have two pins inserted, at a cost of \$1,000 per pin. As Dr. D'Amico began working on C.O., he advised C.O. that the other implants were infected.

14. C.O. was the last patient to leave Florida Dental on June 20, 1999. After Dr. D'Amico finished his work on C.O., he asked C.O. for a check for \$5,300 for the work he had done.

C.O., groggy from the anesthesia, wrote a check to Florida Dental and gave it to Dr. D'Amico.

15. C.O. returned to Florida Dental for several more visits after his initial treatment by Dr. D'Amico. Dr. D'Amico removed all of C.O.'s original implants and put in new implants. The new implants became infected and had to be removed. The site of the implants had to be débrided. Several weeks after the débridement procedure, Dr. D'Amico did a tibial harvest and grafting to the maxilla in an attempt to provide bone which would support an implant.

16. After C.O.'s last visit with Dr. D'Amico, C.O. experienced pain, infection, and swelling. Dr. D'Amico had given C.O. several telephone numbers at which C.O. could reach him. C.O. called the telephone numbers that Dr. D'Amico had given him, but he could not reach Dr. D'Amico at any of the numbers called. Dr. D'Amico did not give C.O. the name of another dentist to call in case of an emergency.

17. C.O. returned to Florida Dental and advised the person in charge that he needed to have something done for him. Another dentist, Dr. Castillo, was called in to attend C.O. C.O. continued to see Dr. Castillo, who was eventually able to insert three implants in C.O.'s mouth.

18. After C.O. began treatment with Dr. Castillo, Dr. D'Amico contacted C.O. in an attempt to get C.O. to return

to him for treatment. C.O. declined further treatment by Dr. D'Amico.

19. Dr. Rumberger reviewed the medical records relating to C.O.'s treatment by Dr. D'Amico. The medical notes consisted of a brief note that five implants were placed and another note stating "Left Tibial Harvest Global Maxillary Cellular Graft." There was no mention of the type of anesthesia that was used. The records did not contain a treatment plan, which should have been done for both the implants and the tibial harvest. There is no documentation that the procedures were thoroughly discussed with C.O. or that C.O. gave informed consent for the procedures. The records do not contain a diagnosis. The x-rays in C.O.'s file were of poor quality and were unsuitable for use in forming an opinion. The records do not justify the course of treatment used by Dr. D'Amico based on the clinical examinations and x-rays of C.O.

Patient J.H.

20. On June 12, 2001, J.H. visited Dr. D'Amico at the Winter Park office, to have four lower teeth extracted. Some of the four teeth were broken and infected, causing J.H. pain. J.H. wanted to be fitted with a partial denture after the lower teeth were extracted.

21. Dr. D'Amico extracted the four teeth on June 12, 2001, while J.H. was under sedation. An assistant was present during at least part of the procedure.

22. On July 11, 2001, J.H. returned to see Dr. D'Amico for examination of the extraction sites and to have an impression made for a partial denture. Dr. D'Amico asked J.H. to remove his upper denture plate. Upon examination, Dr. D'Amico found some redundant soft tissue in the posterior of J.H.'s mouth. Dr. D'Amico told J.H. that the lesions may be precancerous. Dr. D'Amico excised some tissue from both sides of D.H.'s mouth. One sample was sent to a laboratory for testing, and the laboratory results indicated that the lesion was benign. Although Ms. Bruno testified that laboratory work was not being done because Dr. D'Amico was delinquent in paying for laboratory work, the tissue sample that was sent to the laboratory in July was prior to Ms. Bruno's employment with Dr. D'Amico.

23. On July 31, 2001, J.H. returned to Dr. D'Amico's office, where Dr. D'Amico removed tissue from the anterior maxillar vestibule. The lesion in the upper area was probably an epulis fissura, which would not require a biopsy, but would require justification for removal. The tissue was removed to make the area more structurally amenable to wearing a new denture. A sample was not sent to a laboratory for testing.

24. Ten days later, J.H. returned for a post-operative visit, complaining of pain in an area where Dr. D'Amico had excised tissue. J.H. was placed under sedation, and Dr. D'Amico reopened the incision. Dr. D'Amico removed a suture needle from the site. Tiffany Callicott, who was Dr. D'Amico's assistant, was present during the procedure and witnessed the removal of the suture needle. Dr. D'Amico did not tell J.H. that a suture needle had been left in his gum. When J.H. awoke from the anesthesia, Dr. D'Amico told J.H. that he had removed a stone. Later Ms. Callicott told J.H. that Dr. D'Amico had removed a suture needle and not a stone.

25. J.H. had difficulty in getting Dr. D'Amico to fill out and submit insurance claims for J.H.'s dental work. He went to Dr. D'Amico's office to see about the insurance. One of Dr. D'Amico's staff gave J.H. three vials containing tissue samples which Dr. D'Amico had removed from J.H.'s mouth. J.H. took the vials to his family physician so that the samples could be sent to a laboratory.

26. J.H. was billed for laboratory analyses for the two tissue samples that Dr. D'Amico did not send to the laboratory. He was also billed for the work that Dr. D'Amico did in removing the suture needle.

27. Lija Scherer is a medical malpractice investigator with the Department. Part of her responsibilities, include

obtaining medical records for cases which are being investigated. Ms. Scherer obtained an authorization for release of patient information from J.H. and served Dr. D'Amico with a subpoena to produce the medical records for J.H. Dr. D'Amico failed to produce the medical records.

28. The evidence is not clear how the Department obtained the dental records for J.H., but some records were furnished by the Department to Dr. Rumberger. The medical records furnished to Dr. Rumberger consisted of two anesthesia records and a few progress notes, which were in different handwritings and were not signed or identified.

Patient A.P.

29. Dr. D'Amico provided dental treatment to A.P. in September 2001. A.P. had been advised by his regular dentist that his wisdom teeth were impacted and needed to be removed. A.P. went to the office of Dr. McNamara in Winter Park, Florida, to arrange to have the teeth extracted. When A.P. arrived at the office, he was met by Dr. D'Amico, who advised A.P. that Dr. McNamara had retired and that he was taking over the practice.

30. A.P. agreed to allow Dr. D'Amico to treat him. On the first visit, A.P. brought a panoramic x-ray which had been taken by his general dentist. Dr. D'Amico went over the x-ray with A.P., told A.P. the procedure that he would use to extract the

teeth, advised A.P. that he would have anesthesia for the procedure, and advised A.P. of the number of days needed for recovery.

31. A.P. made an appointment with Dr. D'Amico to have his wisdom teeth removed on the Friday of the following week, September 13, 1991. S.P., A.P.'s mother, accompanied A.P. to Dr. D'Amico's office for the surgical procedure. A.P. filled out a medical history form and indicated that he was allergic to codeine.

32. A.P. was taken to a room, which contained only a chair in which A.P. sat, a stool on which Dr. D'Amico sat, and a device by which the anesthesia was to be administered. Dr. D'Amico was accompanied by an assistant. A.P. was given anesthesia through an I.V. and went completely to sleep. Dr. D'Amico extracted the four wisdom teeth.

33. After the surgical procedure, Dr. D'Amico's assistant gave S.P. three prescriptions for A.P. and no oral post-operative instructions.¹ One of the prescriptions was a pain reliever, one was an antibiotic, and one was for inflammation. Neither A.P. nor his mother was advised that the anti-inflammation medication should be started immediately following surgery. A.P. did not have the prescriptions filled until the day after the surgery. A.P. felt that one of the medications contained codeine, and he did not take that

medication. The evidence does not establish that codeine or a medication containing codeine was actually prescribed.

34. After the surgery, A.P. experienced discoloration on the arm in which the I.V. had been given. The arm turned a dark purple from his elbow to his wrist. A.P. was also experiencing pain in his jaw.

35. On the Monday following the procedure, A.P. attempted to contact Dr. D'Amico by telephone. A.P.'s telephone calls were put through to an answering service. A.P. received no answer from Dr. D'Amico on Monday. The next day A.P. again called Dr. D'Amico and spoke with a woman with the answering service. He told the lady that it was an emergency and that he needed to speak to Dr. D'Amico. About ten minutes later, Dr. D'Amico returned A.P.'s telephone call. Dr. D'Amico advised A.P. to apply warm compresses to his arm and that it was normal to have pain after impacted wisdom teeth were removed. A.P. was told to call Dr. D'Amico's office and set up an appointment to see Dr. D'Amico in a week.

36. A.P. was still in a lot of pain and tried to telephone Dr. D'Amico again on Wednesday and Thursday. He was unsuccessful in reaching the doctor. A.P. left messages with the answering service, but Dr. D'Amico did not respond. On Friday, September 20, 2001, A.P. again tried to telephone

Dr. D'Amico. This time he was unable to reach either Dr. D'Amico or the answering service.

37. By September 20, 2001, S.P. became frustrated with the lack of response from Dr. D'Amico to A.P.'s attempts to contact him. S.P. went back to the office where the surgery had been performed, and the office was closed. Dr. D'Amico had advised her that he would be moving his office, so she also went to the location where the office was to be moved, but that office was also closed. She left a letter marked "urgent" at both offices. The letter stated that she and her son had been unable to contact Dr. D'Amico and that her son needed to be checked because he was still in pain and his arm was swollen at the site of the I.V. injection. In the letter, S.P. listed four telephone numbers by which either she or her son could be reached. Neither A.P. nor S.P. received any response from Dr. D'Amico.

38. S.P. called another dentist, Dr. Andre Buchs, and requested that he see A.P. Dr. Buchs, who is board-certified in oral and maxillofacial surgery, saw A.P. on September 21, 2001. Dr. Buchs diagnosed possible phlebitis of the right arm secondary to the intravenous sedation that A.P. had been given by Dr. D'Amico. Phlebitis is an inflammation of the inside of the vein.

39. Dr. Buchs also examined A.P. for the severe pain that A.P. was having in his upper right jaw. He found that there was a hole or perforation in the sinus membrane so that there was a communication between the mouth and the maxillary sinus. About 85 percent of such openings will spontaneously close over a period of time. The treatment was to prevent the area from getting infected with antibiotic therapy and to observe the opening for two to three months. Dr. Buchs prescribed amoxicillin and told A.P. to apply warm compresses to his arm and to avoid anything that would aggravate the perforation. He also advised A.P. that if he was unsuccessful in locating Dr. D'Amico to come by for a follow-up visit. Dr. Buchs saw A.P. again on September 26, 2001. A.P. was doing better by the time of the follow-up visit.

40. On October 17, 2001, A.P. again saw Dr. Buchs. At this time, the opening in the sinus cavity appeared to be closing. Dr. Buchs did see a raised firm lump on A.P.'s inner right arm, which meant that A.P. had a true phlebitis.

41. Ms. Scherer obtained an authorization for release of patient information from A.P. and served Dr. D'Amico with a subpoena for the medical records of A.P. Dr. D'Amico failed to produce the medical records. Thus, there are no medical records available to document the course of treatment for A.P.

Patient M.F.

42. M.F. saw an advertisement in her local newspaper that Dr. D'Amico, a maxillofacial surgeon, was associated with Florida Dental. M.F. had been experiencing discomfort with her set of dentures that was not functioning properly. She felt that implants might be a better solution to her problems and that a maxillofacial surgeon could perform the procedure.

43. In October 1999, she went to see Dr. D'Amico for a consultation. Dr. D'Amico explained that he would place six implants into her upper gum ridge and that it would take approximately four months to complete the process. Dr. D'Amico described the steps in the procedure.

44. A week later M.F. returned to Dr. D'Amico to begin the procedure. After the implants were inserted, M.F. began a waiting period to see if the implants would be rejected. She did have pain with two of the implants, and Dr. D'Amico did further work on those implants, which resolved the pain.

45. During the implant process, M.F. would wait until Dr. D'Amico called her to come in for further work. Frequently he would make an appointment with M.F. and not appear for the appointment. M.F. would go to different locations for her appointments with Dr. D'Amico. Some of the locations appeared to her to be dental offices and some did not.

46. During the healing process, Dr. D'Amico placed healing columns in the implants. Impressions were made for temporary teeth. M.F. wore the temporary teeth until permanent teeth could be made. During one session in which Dr. D'Amico was making an impression for her permanent teeth, he broke one of the front teeth on the temporary set. Dr. D'Amico told M.F. that she could get some Crazy Glue and repair the tooth. M.F. tried to repair the tooth with Crazy Glue, but it would not hold. Thus, M.F. had a missing front tooth for three or four months.

47. After Dr. D'Amico had fitted M.F. with temporary teeth, he told her that he was going to move his dental practice to Boynton Beach. She did not hear from Dr. D'Amico for approximately three or four months. M.F. went to Boynton Beach to look for him, but was unsuccessful in locating him.

48. Dr. D'Amico finally called M.F. and set up an appointment in Winter Park to finish placing the permanent teeth. She went to the appointment. According to M.F., when Dr. D'Amico placed the permanent teeth in her mouth, the teeth did not fit. There was one central incisor in front, and the second incisor was placed to the side. M.F. complained that the upper and lower teeth on both sides did not touch, resulting in difficulty in chewing. The permanent teeth were a different color from her natural lower teeth. Dr. Rumberger opined that

the provision of permanent teeth was beyond Dr. D'Amico's expertise and that Dr. D'Amico should have referred M.F. to another dentist for that procedure.

49. In an attempt to get better articulation between the upper and lower teeth, Dr. D'Amico filed a cap on her lower teeth. The cap had been placed by another dentist. In filing the cap, Dr. D'Amico exposed the metal. He did not offer to repair the cap. Dr. Rumberger did not give an opinion on whether the filing of the cap was below the standard of care. His comment was, "That can happen."

50. Dr. D'Amico told M.F. to try wearing the permanent teeth for two weeks. After the two weeks had passed, M.F. called Dr. D'Amico's office. She was told by the person answering the telephone that Dr. D'Amico would return her call, but he did not. Several months passed before Dr. D'Amico contacted M.F. to come in so that the permanent teeth could be cemented in place. At this time, five of the implants had permanent abutments, but one implant still had a temporary abutment. Dr. D'Amico was going to cement the teeth without replacing the temporary abutment with a permanent abutment. M.F. would not allow him to cement the teeth in place without all the permanent abutments inserted.

51. Dr. D'Amico moved his practice again. M.F. could not locate him and wanted to have the work finished. M.F. had paid

Dr. D'Amico in full, approximately \$20,000, for the work prior to the work being finished. She had the implant work finished by another dentist at a cost of \$9,000. M.F. brought a legal action against Dr. D'Amico to recover her money.

52. The medical records of M.F., which were provided to Dr. Rumberger for his review, were minimal and illegible. There was no mention of a study model being used or that there was a pre-op consultation with a dentist who would construct the permanent teeth. The medical records for M.F. were inadequate.

CONCLUSIONS OF LAW

53. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2000).

54. The Department has the burden to establish the allegations in the Administrative Complaint by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996).

55. The Department alleged that Dr. D'Amico violated Subsection 466.028(1)(i), Florida Statutes (2000) and (2001), which provides that "[f]ailing to perform any statutory or legal obligation placed upon a licensee" shall be a ground for disciplinary action. The Department alleged that Dr. D'Amico violated this statutory provision by violating Florida

Administrative Code Rules 64B5-17.004, 64B5-17.001(4), and 64B5-17.011.

56. Florida Administrative Code Rule 64B5-17.001(4), provides:

(4) Within one month of a dentist's termination of practice or relocation of practice outside the local telephone directory service area of his or her current practice, a notice shall be published in the newspaper of greatest circulation in the county where the dentist practiced which advises patients of the dentist's termination or relocation. The notice shall advise patients that they may obtain copies of their dental records and specify the name, address, and telephone number of the person from whom copies of records may be obtained. The notice shall appear at least once a week for 4 consecutive weeks.

57. The Department has established by clear and convincing evidence that Dr. D'Amico violated Florida Administrative Code Rule 64B5-17.001(4) by failing to place a notice in the newspaper advising his patients that he had relocated his practice after he left Florida Dental and the East Colonial Drive office. Thus, the Department has established that Dr. D'Amico violated Subsection 466.028(1)(i), Florida Statutes (2000) and (2001).

58. Florida Administrative Code Rule 64B5-17.004 provides that "[i]t is the responsibility of every dentist practicing in this State to provide, either personally, through another licensed dentist, or through a reciprocal agreement with another

agency, reasonable twenty-four (24) hour emergency services for all patients under his continuing care."

59. The Department has established by clear and convincing evidence that Dr. D'Amico violated Florida Administrative Code Rule 64B5-17.004, by failing to provide reasonable 24-hour emergency services for the patients under his continuing care. He failed to provide such services for C.O., A.P., and M.F. Thus, the Department established that Dr. D'Amico violated Subsection 466.028(1)(i), Florida Statutes (2000) and (2001).

60. Florida Administrative Code Rule 64B5-17.011 provides that every dentist, unless exempted pursuant to Florida Administrative Code Rule 64B5-17.011(3), shall obtain and maintain medical malpractice insurance or provide proof of financial responsibility as set forth in the rule.

61. The Department presented no evidence concerning Dr. D'Amico's medical malpractice insurance, or lack thereof, or of any failure of Dr. D'Amico to provide proof of financial responsibility. The Department has failed to establish that Dr. D'Amico violated Florida Administrative Code Rule 64B5-17.011.

62. The Department alleged that Dr. D'Amico violated Subsection 466.028(1)(l), Florida Statutes (2001), which provides that "[m]aking deceptive, untrue, or fraudulent representations in or related to the practice of dentistry" is a

ground for disciplinary action. The Department established by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(l), Florida Statutes (2001), by telling J.H. that he had removed a stone from J.H.'s gum, when, in fact, he had removed a suture needle. The evidence established that Dr. D'Amico charged J.H. for laboratory work which was not performed for two tissue samples.

63. The Department alleged that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (1998) and (2001), which provides that a ground for disciplinary action is "[f]ailing 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."

64. In Count II of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (1998), regarding C.O.'s dental records by failing to document the following:

- (a) Adequate diagnostic x-rays;
- (b) His diagnosis of the patient;
- (c) A proposed treatment plan;
- (d) That he informed the patient as to the number of implants to be placed;
- (e) A course of treatment that was supported by the patient's clinical and radiographic findings;
- (f) The results of any clinical examinations or tests rendered to Patient C.O.; and/or

(g) That he informed Patient C.O. of the risks and complications associated with dental implant surgery to ensure that he obtained the patient's informed consent for implant surgery.

65. The Department has established by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (1998), by failing to document a treatment plan for C.O.; by failing to include adequate diagnostic x-rays, such as panoramic radiographs; by failing to document that he advised C.O. of the risks of the procedure and obtained the informed consent of C.O.; by failing to document the results of any clinical examinations of C.O.; by failing to include a diagnosis; and by failing to document a course of treatment that was supported by C.O.'s clinical examination and x-rays.

66. In Count VII of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (2001), regarding J.H.'s dental records by the following acts:

(a) Failing to maintain adequate dental records for J.H., which justified the course of treatment in that J.H.'s x-rays and/or dental records did not support Respondent's course of treatment;

(b) Failing to document his reasons for excising J.H.'s gum tissue on at least three occasions without obtaining laboratory analyses of the excised tissues;

(c) Failing to document that a curved suturing needle was retained in J.H.'s gums; and

(d) Failing to document that he informed J.H. that a sharp, curved suturing needle was retained in his gums and was the source of J.H.'s continuous pain.

67. The Department has established by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (2001), by failing to document why J.H. needed to have multiple excisions of tissue, failing to have adequate records which justified his course of treatment, failing to document that a suture needle was left in J.H.'s gum, and failing to document that he advised J.H. that a suture needle had been left in his gum.

68. In Count X of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (2000), regarding A.P.'s dental records by the following:

(a) Failing to document his medical reasons for not utilizing A.P.'s obvious and distinctive veins for atraumatic phlebotomy entry; and

(b) Failing to document his medical reasons for prescribing Codeine-based medications to A.P. despite being informed of A.P.'s allergy to Codeine.

69. The Department has failed to establish by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(m), Florida Statutes (2000), as it relates to A.P.'s dental records on the grounds set forth in the Administrative Complaint. The Department has failed to

establish that Dr. D'Amico did prescribe codeine-based medications to A.P.; thus, the Department has failed to establish that Dr. D'Amico failed to document his reason for prescribing codeine for A.P. The Department failed to present evidence that Dr. D'Amico was required to document the reasons for failing to use certain veins for the intravenous site.

70. The Department alleged that Dr. D'Amico violated Subsection 466.028(1)(t), Florida Statutes (2001), which provides that "[f]raud, deceit, or misconduct in the practice of dentistry or dental hygiene" is a ground for disciplinary action. The Department has established by clear and convincing evidence that Dr. D'Amico did violate Subsection 466.028(1)(t), Florida Statutes (2001), by charging J.H. for laboratory work that was not done. The Department has failed to establish that J.H. should not have been charged for the removal of the suture needle.

71. The Department alleged that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (1998), (2000), and (2001), which provides that a ground for disciplinary action is the following:

(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. For purposes of this paragraph, it shall be legally presumed that a dentist is not guilty of incompetence or negligence by declining to treat an individual if, in the dentist's professional judgment, the dentist or a member of her or his clinical staff is not qualified by training and experience, or the dentist's treatment facility is not clinically satisfactory or properly equipped to treat the unique characteristics and health status of the dental patient, provided the dentist refers the patient to a qualified dentist or facility for appropriate treatment. . . .

72. In Count I of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (1998), by the following acts:

- (a) Failing to use adequate x-rays to diagnose Patient C.O.'s dental condition;
- (b) Failing to inform Patient C.O. about the risks and complications of dental implant surgery;
- (c) Failing to inform Patient C.O. about the number of implants that would be needed to complete treatment;
- (d) Failing to implement the appropriate measures to prevent infection after performing dental implant surgery;
- (e) Failing to appropriately treat the infection that developed after dental implant surgery;
- (f) Failing to refer Patient C.O. to a specialist for treatment for post-implant surgery infection; and/or
- (g) Being inaccessible to Patient C.O. once the implants failed.

73. The Department did establish by clear and convincing evidence that Dr. D'Amico did violate Subsection 466.028(1)(x),

Florida Statutes (1998), by failing to use adequate x-rays to diagnose C.O.'s dental condition. The x-rays contained in C.O.'s file were of poor quality and insufficient to use in making a diagnosis. Dr. D'Amico also violated Subsection 466.028(1)(x), Florida Statutes (1998), by failing to inform C.O. of the risks and complications involved in the procedures performed, and by being inaccessible to C.O. after the last surgical procedure. The Department did not establish by clear and convincing evidence that Dr. D'Amico failed to inform C.O. of the number of implants that would be needed to complete treatment, that he failed to implement appropriate measures to prevent infection, that he failed to appropriately treat the infection which occurred after surgery, or that he failed to send C.O. to a specialist for treatment of a post-implant surgery infection. Although Dr. D'Amico did not refer C.O. to another dentist when he was not available, the evidence does not establish that Dr. D'Amico should have referred C.O. to a particular type of specialist for treatment.

74. In Count IV of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2001), by the following acts regarding J.H.:

- (a) Making negligent and wrongful diagnoses, on at least three separate occasions;

- (b) Diagnosing Patient J.H. with oral cancer without obtaining laboratory analyses and/or pathology reports;
- (c) Performing multiple unnecessary surgeries on Patient J.H.;
- (d) Leaving a suture needle in Patient J.H.'s mouth after surgery;
- (e) Failing to inform Patient J.H. that he left a curved suturing needle in his mouth; and/or
- (f) Deceiving Patient J.H. by incorrectly informing the patient that he removed a stone from his gums, rather than a suturing needle.

75. The Department did establish by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2001), by leaving the suture needle in J.H.'s gum, failing to inform J.H. that he had left the suture needle, and telling J.H. that he had removed a stone rather than a suture needle. The Department failed to establish that Dr. D'Amico made wrongful or negligent diagnoses on three separate occasions, diagnosed J.H. with oral cancer, and performed multiple unnecessary surgeries on J.H. The evidence established that Dr. D'Amico told J.H. that the lesions may be precancerous, not that they were cancer. Dr. D'Amico adequately explained why he excised tissue in the anterior portion of J.H.'s mouth.

76. In Count VIII of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2001), by the following acts:

(a) Negligently perforating Patient A.P.'s sinus cavity during extraction of his impacted wisdom teeth;

(b) Negligently prescribing Patient A.P. a codeine-based pain medication;

(c) Failing to use Patient A.P.'s distinctive veins for atraumatic phlebotomy entry at the time he injected Patient A.P. for surgery;

(d) Failing to explain and/or instruct Patient A.P. on the medications, he prescribed;

(e) Failing to be accessible to Patient A.P. for post-operative care; and/or

(f) Failing to arrange for emergency services for Patient A.P.

77. The Department did establish by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2001), by failing to instruct A.P. on the medications that he was prescribing, failing to be accessible to A.P. after the extraction of the wisdom teeth, and failing to arrange for emergency services for A.P. after the extractions when Dr. D'Amico was not available to the patient. The Department did not establish that the perforation of the sinus cavity was below the standard of care, that the selection of the intravenous site was below the standard of care, and that Dr. D'Amico prescribed a codeine-based medication for A.P.

78. In Count XI of the Administrative Complaint, the Department alleged that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2000), by the following acts:

(a) Failing to complete Patient M.F.'s dental care and treatment;

- (b) Failing to refer Patient M.F. to another dentist for treatment;
- (c) Providing Patient M.F. with a set of permanent teeth that did not function properly;
- (d) Exposing the metal on one of Patient M.F.'s teeth by filing the capped teeth down too low; and/or
- (e) Abandoning Patient M.F. without completing her treatment and making emergency services available to her.

79. The Department has established by clear and convincing evidence that Dr. D'Amico violated Subsection 466.028(1)(x), Florida Statutes (2000), by failing to complete M.F.'s dental care and treatment, by failing to refer her to another dentist for treatment, and by failing to make emergency services available to M.F. when he was not available. The Department established that Dr. D'Amico fell below the standard of care in providing M.F. with permanent teeth that did not function appropriately because the provision of permanent teeth was beyond Dr. D'Amico's expertise. The Department failed to establish by expert testimony that grinding down a cap until the metal is exposed is below the standard of care.

80. The Department alleged that Dr. D'Amico violated Subsection 456.072(1)(bb), Florida Statutes (2001), which provides that the following constitutes a ground for disciplinary action:

- (bb) Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia

commonly used in surgical, examination, or other diagnostic procedures. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of a patient and is not within the standard of care of the professional, regardless of the intention of the professional.

81. The Department has established by clear and convincing evidence that Dr. D'Amico violated Subsection 456.072(1)(bb), Florida Statutes (2001), by leaving a suture needle in J.H.'s gum.

82. Dr. D'Amico has been previously disciplined by the Board of Dentistry. On April 10, 2001, a Final Order was entered by the Board of Dentistry approving a settlement agreement; reprimanding Dr. D'Amico; imposing an administrative fine of \$7,000; reimbursing the Board of Dentistry for the costs of the case; requiring completion of continuing education courses; and placing Dr. D'Amico on probation for five years, while practicing under the indirect supervision of a monitor approved by the Board of Dentistry. On October 11, 2001, an Order of Emergency Suspension of License was issued against Dr. D'Amico for failure to adhere to the terms of his probation.

83. Florida Administrative Code Rule 64B5-13.005 sets forth the disciplinary guidelines to be used by the Board of Dentistry in imposing penalties. Aggravating factors to be considered in imposing penalties, include prior discipline and

the actual damage caused by the dentist's actions. Considering these factors, the appropriate penalty is revocation of Dr. D'Amico's license.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered finding that Dr. D'Amico violated Subsections 466.028(1)(m) and 466.028(1)(x), Florida Statutes (1998); Subsections 466.028(1)(i) and 466.028(1)(x), Florida Statutes (2000); and Subsections 466.028(1)(i), 466.028(1)(l), 466.028(1)(m), 466.028(1)(t), 466.028(1)(x), and 456.072(1)(bb), Florida Statutes (2001). It is further recommended that Dr. D'Amico's license be revoked.

DONE AND ENTERED this 23rd day of July, 2004, in Tallahassee, Leon County, Florida.



SUSAN B. KIRKLAND
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 23rd day of July, 2004.

ENDNOTE

1/ A.P. testified that he was given an "after-care sheet" of instructions, but the evidence is not clear whether he received that from Dr. D'Amico's office or from the subsequent treating dentist, Dr. Buchs.

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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.