STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF DENTISTRY,	)	
Petitioner,	)	
vs.	)	Case No. 11-5793PL
JOSEPH GAETA, D.D.S.,	)	
Respondent.	)	

RECOMMENDED ORDER

This case came before Administrative Law Judge John G. Van Laningham for final hearing by video teleconference on February 28-29, 2012, at sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Geoffrey F. Rice, Esquire
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For Respondent: Max R. Price, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent, a dentist, failed to maintain adequate records regarding his treatment of patient R.S. and/or provided R.S. dental care that fell below

minimum standards of performance, as Petitioner alleges. If Respondent committed any of these offenses, it will be necessary to determine an appropriate penalty.

PRELIMINARY STATEMENT

On March 20, 2009, Petitioner Department of Health issued a two-count Amended Administrative Complaint ("Complaint") against Respondent Joseph Gaeta, D.D.S. In April 2009, Dr. Gaeta timely requested a formal hearing, and on November 10, 2011, the Department referred the matter to the Division of Administrative Hearings. The undersigned scheduled a multiday hearing to begin on February 28, 2012.

Both parties were represented by counsel at the hearing, which went forward as planned. The Department's witnesses were Dr. Gaeta and Dr. Victor Spiro. Received in evidence during the Department's case were Petitioner's Exhibits 1-6, 8[1], 9(b), 9(d), and 9(e). Dr. Gaeta called Dr. Robert Fish as a witness and testified on his own behalf. Respondent's Exhibits 1, 4-7, and 10 were admitted.

The final hearing transcript, comprising four volumes, was filed on March 16, 2012. Motions to enlarge the time for filing proposed recommended orders were granted, resulting in a deadline of April 9, 2012. Each party timely filed a Proposed Recommended Order, and these have been considered.

Unless otherwise indicated, citations to the Florida Statutes refer to the 2005 Florida Statutes.

FINDINGS OF FACT

Introduction

1. At all times relevant to this case, Respondent Joseph Gaeta, D.D.S., was licensed to practice dentistry in the state of Florida.

2. Petitioner Department of Health (the "Department") has regulatory jurisdiction over licensed dentists such as Dr. Gaeta. In particular, the Department is authorized to file and prosecute an administrative complaint against a dentist, as it has done in this instance, when a panel of the Board of Dentistry has found that probable cause exists to suspect that the dentist has committed a disciplinable offense.

3. Here, the Department alleges that Dr. Gaeta committed two such offenses. In Count I of the Complaint, the Department charged Dr. Gaeta with the offense defined in section 466.028(1)(m), alleging that he failed to keep written dental records justifying the course of treatment of a patient named R.S., whom Dr. Gaeta saw six times over a five-month period from November 15, 2002, through April 11, 2006. In Count II, Dr. Gaeta was charged with incompetence or negligence——again vis-à-vis R.S.——allegedly by failing to meet the minimum standards of performance in diagnosis and treatment when

measured against generally prevailing peer performance, an offense under section 466.028(1)(x).

The Material Historical Facts

4. The events giving rise to this case began on November 15, 2005, when R.S., a retired septuagenarian who spent winters in Florida but considered Michigan——where he resided the rest of the year——to be his home, arrived at Dr. Gaeta's office with an acute problem, namely a loose tooth. The tooth——#24, an incisor located in the lower jaw, center-left——had recently been knocked loose when R.S. bit into a cashew. Dr. Gaeta's office had scheduled R.S. for an immediate visit when he had called for an appointment, advising that they would "work [him] in."

5. Upon being seen, R.S. informed Dr. Gaeta that he would be leaving in a couple of days for a cruise, and that, consequently, he wanted the bare minimum amount of dental treatment. Dr. Gaeta performed a comprehensive examination of R.S.'s mouth and took X-rays, including periapical X-rays of front tooth #9 (upper jaw, center-left) and tooth #24 . The examination revealed multiple problems besides the loose tooth, including lingual and buccal decay, bone loss, periodontal disease, and a loose amalgam filling in tooth #29 (lower right bicuspid), which filling popped out when probed. These issues were recorded in R.S.'s dental record.

6. Dr. Gaeta prepared a treatment plan in accordance with R.S.'s desire to have as little dental work done as possible. Dr. Gaeta proposed to extract tooth #24, which was noted to have class III mobility (meaning it was quite loose as a result of bone loss caused by periodontal disease), and, in place of the absent tooth, substitute an artificial tooth known as a pontic, which would be supported by a five-unit bridge using the adjacent teeth (##22-23 and ##25-26) as abutment teeth. He proposed to place a crown on tooth #9 due to lingual decay, and another on tooth #29, from which the amalgam filling had fallen out. This treatment plan was documented in R.S.'s chart.

7. Dr. Gaeta informed R.S. of his diagnoses, explained the treatment options, and obtained verbal consent to proceed with the prescribed course of treatment (described above). Dr. Gaeta noted in R.S.'s dental record that he "gave pt [patient] tx [treatment] plan," but did not otherwise memorialize the substance of their discussion, nor did he obtain written consent to treatment from R.S.

8. After agreeing on a course of treatment, R.S. paid in advance for the procedures he had orally authorized Dr. Gaeta to perform. Thereafter, an anesthetic drug known by its brand name, Septocaine®, was injected to numb R.S.'s mouth, and Dr. Gaeta pulled tooth #24. He also "prepped" tooth #9, tooth #24, and the abutment teeth (##22-23 and ##25-26) and seated

temporary crowns on them. Finally, Dr. Gaeta installed a temporary bridge, which would remain in R.S.'s mouth until the arrival and placement of a custom-made fixture from a dental laboratory. All of this dental work (including the use of the anesthetic), which was performed on November 15, 2005, was noted in R.S.'s chart.

9. The evidence is in conflict as to whether Dr. Gaeta gave R.S. "post-operative" instructions following the provision of any dental treatments, including but not limited to the procedures performed on November 15, 2005. Dr. Gaeta testified that he did provide such instructions, as necessary, but did not note having done so in R.S.'s chart (which is undisputed) because in his opinion the recordkeeping laws do not require dentists to document the occurrence or substance of such routine dentist-patient communications (a legal point with which the Department disagrees). R.S. testified (via deposition) that Dr. Gaeta never provided any instructions. Neither witness is more believable than the other on this issue. As a result, the undersigned is unable to determine without hesitancy that Dr. Gaeta failed to provide post-operative instructions, as the Department alleged. The evidence offered in support of this allegation, in sum, is legally insufficient because it is not clear and convincing.

10. R.S. next saw Dr. Gaeta on January 3, 2006. This appointment was for the purpose of making final impressions for the crowns, but R.S. presented with a new problem, which was that tooth #9 was painful. A panoramic X-ray was taken and the fact noted in R.S.'s record. Based on that X-ray plus the previous pariapical X-ray of tooth #9, which radiographs showed significant decay and a large filling in the tooth, together with the patient's complaint that the tooth was sensitive (a symptom noted in the chart), Dr. Gaeta determined that tooth #9 needed root canal therapy and documented his conclusion in the chart.

11. Dr. Gaeta performed a root canal on tooth #9. The Department has alleged that Dr. Gaeta failed to measure the root canal length using either an X-ray or, alternatively, an instrument called an apex locator. Dr. Gaeta testified credibly that he used an apex locator to determine that the canal length was 15 millimeters. This measurement is noted in R.S.'s record, and Dr. Gaeta's testimony regarding the use of an apex locator is credited. The Department further alleged that Dr. Gaeta failed to take a post-operative X-ray to determine whether the root canal had been completely filled. The record, however, includes such an X-ray. Finally, the Department alleged that Dr. Gaeta failed to use a rubber dam when performing the root canal procedure on tooth #9. But based on Dr. Gaeta's credible

testimony, the undersigned finds that Dr. Gaeta did, in fact, use a rubber dam. Dr. Gaeta did not note in R.S.'s record the use of an apex locator or rubber dam; he denies having an obligation to document the use of common dental implements in a patient's chart.

12. Dr. Gaeta gave R.S. Septocaine® to produce local anesthesia during the root canal procedure. He did not note this fact, or the strength and dosage of the anesthetic drug administered, in R.S.'s chart. Dr. Gaeta maintains that there is no legal requirement to record such information in the patient's dental record.

13. R.S. saw Dr. Gaeta four more times, on February 7, March 27, March 31, and April 11, 2006. Over the course of these visits, excluding the final one in April, Dr. Gaeta placed permanent crowns on tooth #9 and tooth #29 and completed the dental work required to install the permanent bridge spanning tooth #22 and tooth #26. The details of these visits are largely irrelevant, except as set forth below.

14. During the visit on April 11, 2006, Dr. Gaeta learned that R.S.'s tooth #29, which had been crowned earlier that year, had broken near the gum line. The Department did not allege that Dr. Gaeta's treatment of tooth #29 caused the tooth to fracture, but rather charged that Dr. Gaeta: (a) placed the crown without first determining whether the tooth was strong

enough to support it; and (b) failed to determine, in April 2006, why the tooth had broken. The Department failed to prove these allegations by clear and convincing evidence, as explained below.

15. Regarding the first of these allegations, it must be observed, initially, that Dr. Gaeta is charged with failing to determine whether tooth #29 could support a crown, not with making an improper determination as measured against the standard of care. Consequently, unless the evidence shows clearly and convincingly that Dr. Gaeta placed the crown despite having not made up his mind one way or the other about the strength of tooth #29, Dr. Gaeta must be found not guilty. Indeed, strange as it sounds, Dr. Gaeta would be not guilty even if the evidence showed that he determined tooth #29 was not strong enough to support a crown and proceeded to place one anyway, for the charge, again, is failing to make a determination, not making a mistaken determination.

16. That said, it is undisputed that the only reasonable alternative to placing a crown on tooth #29 was extraction. Contrary to the Department's allegation, the evidence suggests that Dr. Gaeta did, in fact, determine that tooth #29 might be saved with a crown——a course of treatment that would spare R.S. the loss of yet another tooth. Without more than is present in the instant record, the mere fact that tooth #29 later broke is

insufficient to prove, clearly and convincingly, that Dr. Gaeta's judgment fell below the standard of care, much less that he gave little or no thought to the question of whether the tooth could support a crown, as charged.

17. To be sure, the Department's expert witness, Dr. Spiro, testified that, in his opinion, tooth #29 should have been pulled because, he "believe[s]," the "crown to root ratio" was too high. Putting aside that Dr. Gaeta was not actually charged with violating the standard of care by crowning a tooth that could not support a crown, Dr. Spiro did not give an opinion——based on generally prevailing peer performance——as to what an acceptable crown-to-root ratio would be, nor did he (or anyone else) testify about what the crown-to-root ratio of R.S.'s tooth #29 actually was, making it impossible for the undersigned to determine independently whether the latter ratio was too high relative to the standard of care. Thus, Dr. Spiro's belief that Dr. Gaeta violated the standard of care in placing a crown on tooth #29 was an unpersuasive "net opinion" that was, moreover, plainly personal in nature as opposed to being evidently grounded on an objective standard deduced from knowledge of the prevailing practices of dentists as a group. For these reasons, Dr. Spiro's testimony in this regard is not accepted as clear and convincing evidence in

support of the allegation that Dr. Gaeta failed to determine whether tooth #29 could support a crown.

18. As for the allegation that Dr. Gaeta failed to determine why tooth #29 broke, the evidence shows otherwise. It is noted in R.S.'s chart that during the visit on April 11, 2006, Dr. Gaeta explained to R.S. that he (R.S.) was "placing extreme force" on tooth #29, which was the patient's "only posterior tooth on [the] lower right" jaw. Even assuming for argument's sake, therefore, that the standard of care required Dr. Gaeta to make a determination as to why the tooth had broken, the evidence fails to prove that he did not do so. Further, the Department neither alleged nor proved that Dr. Gaeta erred, or otherwise violated the standard of care, in determining that tooth #29 had broken apart because, being R.S.'s only lower right rear tooth, it was exposed to extreme force when R.S. chewed his food. This particular allegation, in sum, was not proved by clear and convincing evidence.

The Charges

19. The charges against Dr. Gaeta are set forth in the Complaint under two counts. In Count I, the Department accused Dr. Gaeta of failing to keep adequate dental records, an offense disciplinable pursuant to section 466.028(1)(m). The Department alleged that, in the course of treating R.S., Dr. Gaeta violated the recordkeeping requirements in 13 separate instances, which

are identified in paragraph 27, subparagraphs a) through m) of the Complaint. In Count II, the Department charged Dr. Gaeta with dental malpractice, which is punishable under section 466.028(1)(x). Fifteen separate instances of alleged negligence in the treatment of R.S. are set forth in paragraph 31, subparagraphs a) through o).

20. The allegations in paragraphs 27 and 31 are largely parallel to one another, so that, when aligned side-by-side, they can be examined in logical pairs. Generally speaking, the Department's theory in relation to each allegation-pair can be expressed as follows: Where the circumstances required that the dental act "X" be done for R.S. to meet the minimum standards of performance as measured against generally prevailing peer performance, Dr. Gaeta failed to do X, thereby violating the standard of care. Dr. Gaeta also failed to record doing X in the patient's record, thereby violating the recordkeeping requirements.

21. The parallel propositions comprising each allegation-pair are mutually exclusive. For example, if Dr. Gaeta did not, in fact, do X, then he might be found to have violated the standard of care, if the Department were successful in proving, additionally, that, under the circumstances, X was required to be done to meet the minimum standards of performance. If Dr. Gaeta did not do X, however, he obviously could not be

disciplined for not recording in R.S.'s chart that he actually performed X.[2] (If a dentist were to write in the patient's chart that he performed X when in fact he had not performed X, he would be making a false record; that would be a recordkeeping violation, but it is not the sort of misconduct with which the Department has charged Dr. Gaeta.)

22. On the other hand, if Dr. Gaeta in fact did X and failed to note in R.S.'s chart having done X, then——if the law required Dr. Gaeta to document the performance of X——he would be guilty of a recordkeeping violation. But if Dr. Gaeta performed X, then (with one exception) he could not simultaneously be found guilty, here, of a standard-of-care violation, even if he performed X negligently. This is because nearly all of the standard-of-care allegations against Dr. Gaeta involve omissions, i.e., alleged failures to act, which means that the Department's burden was to prove that Dr. Gaeta did not do X when the circumstances required that X be performed. Such a violation of the standard of care (namely, not doing X when X should have been done) is quite different from performing X negligently; the latter would be a disciplinable offense, but (with one exception) it is not the type of wrongdoing with which the Department has charged Dr. Gaeta.

23. The specific charges against Dr. Gaeta are reproduced in the table below, which places the corresponding allegation-

pairs side-by-side in separate rows. The standard-of-care violations set forth in Count II are located in column A, while the recordkeeping violations charged in Count I are listed in column B. For ease of presentation, the undersigned has reordered the allegations to some extent. Further, in several instances a subparagraph has been divided into two parts. For example, paragraph 31 k) of the Complaint is shown in the table as paragraphs 31 k.1) and 31 k.2). An empty cell——e.g., column B, row 10 (hereafter, "B10")——denotes the absence of a corresponding allegation. Text which has been stricken through, as in B12, reflects allegations that the Department either withdrew at hearing or conceded in its Proposed Recommended Order. These allegations were not proved and will not be discussed further in this Recommended Order.

24. The Department charges Dr. Gaeta as follows:

	A **Count II, ¶ 31: Alleged Standard-of-Care Violations**	**B** **Count I, ¶ 27: Alleged Recordkeeping Violations**
1	a) [F]ail[ing] to provide a comprehensive diagnosis with adequate radiographs, study models or impressions, periodontal depth probe charting, tooth charting and a comprehensive treatment plan prior to initiating root canal treatment and crown/bridge placement	a.1) [F]ailing to record an overall comprehensive written diagnosis, with periodontal depth probe and tooth charting, failing to document a written comprehensive treatment plan . . . .
2	k.1) [F]ail[ing] to provide adequate diagnosis, including symptoms, with an accompanying treatment plan for Patient R.S. prior to initiating root canal	i.1) [F]ailing to record an adequate diagnosis, symptoms, and accompanying treatment plan for Patient R.S. prior to initiating root canal treatment of tooth number 9 . . . .

	treatment of tooth number 9	
3	k.2) Respondent failed to record adequate exam results and/or perform a complete diagnosis in support of his root canal treatment for Patient R.S.	i.2) Respondent failed to record adequate exam results and/or perform a complete diagnosis in support of his root canal treatment for Patient R.S.
4	c) [F]ail]ing] to fully determine through diagnostic exam results whether teeth numbers 22 and 26 were appropriate abutment teeth for a five-unit bridge and why an anterior lower five-unit bridge was needed[.]	a.2) [F]ailing to document whether teeth numbers 22 and 26 were appropriate abutment teeth for a five-unit bridge and why an anterior lower five-unit bridge was needed[.]
5	e) [F]ail[ing] to formulate and/or present treatment options with explanation of risks/benefits to, and fail[ing] to obtain informed consent from, Patient R.S. prior to initiating any of the treatments provided[.]	c) [F]ailing to document presenting treatment options with explanation of risks/benefits to, or obtaining informed consent from, Patient R.S. prior to initiating any of the treatments provided[.]
6	f) [F]ail[ing] to fully determine through diagnostic exam results where the amalgam filling was located on tooth number 29 and why it came loose as observed during the initial November 15, 2005, visit and fail[ing] to provide adequate diagnosis to justify seating of a crown on the tooth in lieu of restoring the filling	d) [F]ailing to notate where the amalgam filling was located on tooth number 29 and why it came loose as observed during the initial November 15, 2005, visit and failing to provide a written diagnosis to justify seating of a crown on the tooth in lieu of restoring the filling . . . .
7	g) [F]ail[ing] to provide post-op instructions or discussions for Patient R.S. following procedures performed November 15, 2005, January 3, 2006, and/or for any other treatment visits notated[.]	e) [F]ailing to record in the treatment notes that post-op instructions or discussions for Patient R.S. were provided appropriately following procedures performed November 15, 2005, January 3, 2006, and/or for any other treatment visits notated[.]
8	l) [F]ailing to take a diagnostic working length radiograph, and/or use of an apex locator, and/or take a post-op fill radiograph during the root canal treatment provided on or about January 3, 2006[.]	j) [F]ailing to record a diagnostic working length radiograph, and/or use of an apex locator, and/or tak[e] a post-op fill radiograph during the root canal treatment provided on or about January 3, 2006[.]
9	m) [F]ail[ing] to use a rubber dam was used during the January 3, 2006, root	k) [F]ailing to record that a rubber dam was used in the January 3, 2006, root canal

	canal procedure, and/or indicate why it was not employed[.]	procedure, and if it was not, why it was not employed[.]
10	b) [F]ail[ing] to either fully diagnose and/or properly treat the periodontal condition [that was] noted in Patient R.S.'s mouth during the initial exam November 15, 2005, before embarking upon complex restorative treatments including root canal and crown and bridge restorations[.]	
11	n.1) [S]eat[ing] a crown on tooth number 29 in early 2006, which broke off with the tooth at the gum line[,] without first determining if tooth number 29 was strong enough to support a crown	
12	n.2) [F]ail[ing] to diagnose and determine why the crown seated a few months earlier at tooth number 29 broke off with the tooth[.]	~~m.1) [F]ailing to record in treatment notes for Patient R.S.'s April 6, 2006, visit, why the crown seated a few months earlier at tooth number 29 broke off with the tooth at the gum line . . . .~~
13		l) [F]ailing to record the types and amounts of anesthetic used during the January 3, 2006, root canal procedure[.]
14	~~i) [F]ail[ing] to take a diagnostic (preferably periapical) radiograph of Patient R.S.'s tooth number 9 prior to initiating root canal treatment of the tooth . . . .~~	g) [F]ailing to take and/or interpret in the treatment notes a diagnostic (preferably periapical) radiograph of Patient R.S.'s tooth number 9 prior to initiating root canal treatment of the tooth . . . .
15	~~j) [F]ail[ing] to perform any thermal, pulp, or bite percussion tests performed on Patient R.S. prior to initiating root canal treatment on tooth number 9[.]~~	h) [F]ailing to record the results of any thermal, pulp, or bite percussion tests performed on Patient R.S. prior to initiating root canal treatment on tooth number 9[.]
16	~~d) [F]ail[ing] to fully determine through diagnostic exam results why an extraction of tooth number 24 was required and why a five-unit bridge was being fabricated instead of a three-unit bridge or some~~	~~b) [F]ailing to clarify why an extraction of tooth number 24 was required and why a five-unit bridge was being fabricated instead of a three-unit bridge or some other restorative option in the treatment notes [dated] November 15, 2005, which~~

	~~other restorative option [on] November 15, 2005, during which Respondent extracted tooth number 24 and then prepared for a five-unit bridge from tooth sites 22-26 to replace the extracted tooth[.]~~	~~indicate that Respondent extracted tooth number 24 and then prepared for a five unit bridge from tooth sites 22-26 to replace the extracted tooth[.]~~
17	~~h) [F]ail[ing] to inform Patient R.S. that temporary or permanent parathesia is a known risk of extractions when the patient presented on December 9, 2005, complaining on numbness in the lingual area proximate to the extraction/bridge prep site. Respondent further failed to re-check the parathesia and note progress at subsequent appointments, and/or failed to advise Patient R.S. of possible referral to an oral surgeon if needed[.]~~	~~f) [F]ailing to note informing Patient R.S. that temporary or permanent parathesia is a known risk of extractions when the patient presented on December 9, 2005, complaining on numbness in the lingual area proximate to the extraction/bridge prep site. Respondent further failed to re-check the parathesia and note progress at subsequent appointments, and/or fail[ed] to advise Patient R.S. of possible referral to an oral surgeon if needed[.]~~
18	~~o) [F]ail[ing] to provide adequate diagnostic results to justify a proposed plan to seat crowns at tooth numbers 27 and 28, along with placing implants at tooth numbers 29 and 30, after the crown seated on tooth number 29 broke off with the tooth at the gum line.~~	~~m.2) [F]ailing to record diagnostic results to justify a proposed plan to seat crowns at tooth numbers 27 and 28, along with placing implants at tooth numbers 29 and 30.~~

The Expert Testimony

25. The Department presented the testimony of Victor Spiro, D.D.S., on issues relating to the standard of care. Dr. Spiro was shown to have formulated his opinions without the benefit of some potentially relevant information available to the Department, e.g., the deposition of R.S., which he had not read, and some of the X-rays Dr Gaeta had taken. In addition, he misunderstood certain facts, such as the length of the dentist-patient relationship between Dr. Gaeta and R.S., which

was about six months, not many years as Dr. Spiro believed. These considerations were marginally damaging to Dr. Spiro's credibility, but not as devastating as Dr. Gaeta has argued.

26. The real problems with Dr. Spiro's testimony go to the heart of what an expert opinion must contain to be credited as evidence of a standard-of-care violation. To be convincing, the opinion needs to establish clearly the existence of a standard of care in the profession and explain how such standard applies to the facts of the case.[3] As the statute plainly specifies, the standard of care must be a minimum standard of performance, not the optimal standard or best practice.[4] The standard, moreover, must be based on "generally prevailing peer performance", that is, be "recognized as necessary and customarily followed in the community."[5] It is therefore not sufficient for the standard-of-care expert (who likely has a keen interest in seeing his views "recognized as being 'correct' and 'justifiable'") merely to declare his personal opinions or practices and invite the fact-finder, either implicitly or explicitly, to extrapolate——from one practitioner's ideas about how the profession should perform——a generally applicable, minimum standard for all practitioners.[6] Instead, to be credited, an expert's opinion on the standard of care must result from a process of deductive reasoning, based demonstrably upon an informed understanding[7] of

what the dental community, as a whole, generally does in a given situation.[8]

27. Here, Dr. Spiro did not convincingly articulate minimum standards of performance against which the undersigned, as fact-finder, can independently measure Dr. Gaeta's conduct. In addition, Dr. Spiro did not establish that his criticisms of Dr. Gaeta were based on a comparison of Dr. Gaeta's conduct to that which generally prevails in the relevant peer group. Indeed, the undersigned is not persuaded, much less convinced, that Dr. Spiro is familiar with the generally prevailing peer practices, if any, relevant to the charges in this case. In sum, a thorough review of Dr. Spiro's testimony leaves the undersigned with the distinct impression that Dr. Gaeta failed to measure up to Dr. Spiro's standards of performance. This is not a factually sufficient basis for the imposition of discipline.

28. Because the Department failed to meet its burden of proof with regard to establishing the applicable minimum standards of care, it is unnecessary to make findings based on the testimony of Dr. Fish, whose opinions Dr. Gaeta offered to rebut those of Dr. Spiro.

Ultimate Factual Determinations

29. The evidence presented with regard to A1, A2, and A3 does not clearly and convincingly demonstrate that Dr. Gaeta

"failed" to provide a "comprehensive diagnosis" inasmuch as the existence of a standard of care defining and requiring such a diagnosis was not proved and, in any event, Dr. Gaeta did diagnose and treat multiple problems in R.S.'s mouth. The evidence does not prove that Dr. Gaeta improperly diagnosed any of the conditions he treated. The evidence fails to establish convincingly any minimum standards of performance requiring the diagnostic tests that Dr. Gaeta allegedly failed to perform. There is, on the other hand, evidence that Dr. Gaeta performed diagnostic work on R.S., including periodontal depth probing. The evidence fails to establish convincingly the existence of a standard of care requiring (or defining) the provision of a "comprehensive treatment plan." There is, however, evidence that Dr. Gaeta developed a treatment plan for R.S., consistent with the patient's desires, which was implemented. Dr. Gaeta is not guilty of the charges reproduced in A1, A2, and A3 of the table above.

30. The evidence fails to prove clearly and convincingly that Dr. Gaeta failed to record or include in R.S.'s chart any of the diagnoses he made, the results of examinations performed, or the X-rays taken. A dispute exists between the parties regarding whether the Department possessed all of the records comprising R.S.'s chart. The evidence suggests, as Dr. Gaeta maintains, that some materials might be missing. Given the many

years that elapsed between the time Dr. Gaeta treated R.S. and the commencement of this proceeding, during which period Dr. Gaeta sold the dental practice in which R.S. had been seen and, as a result, surrendered exclusive control over R.S.'s chart, it is easy to accept that a few documents or X-rays have gotten lost or been misplaced. Dr. Gaeta was not charged, however, with failing to preserve dental records he had made, but rather with failing to enter certain required information upon R.S.'s chart.[9] Therefore, he is not subject to discipline in this case for losing materials originally contained in R.S.'s chart.[10] In sum, Dr. Gaeta is not guilty of the charges set forth in B1, B2, and B3 in the table above.

31. Contrary to the allegations in A4, the evidence shows that Dr. Gaeta did, in fact, make a determination based on diagnostic examination results, including X-rays, that a five-unit bridge spanning tooth #22 and tooth #26 was appropriate. The evidence thus fails to prove clearly and convincingly that Dr. Gaeta gave little or no thought to the propriety of a five-unit bridge. He is not guilty of violating the standard of care as alleged in A4, even if his determination were wrong (which the evidence does not clearly establish either).

32. Dr. Gaeta documented in R.S.'s chart the plan to install a five-unit bridge as a means of replacing tooth #24 with a false tooth. In doing so Dr. Gaeta clearly manifested

his determination that the abutment teeth were appropriate. Although he did not write a detailed explanation of why a five-unit bridge was needed, Dr. Gaeta did prepare a dental record that justifies this course of treatment; thus he is not guilty of the recordkeeping violation alleged in B4.

33. With regard to A5, the evidence is insufficient to prove clearly and convincingly that Dr. Gaeta failed to present treatment options, explain risks and benefits, and obtain informed consent before treating R.S., for there is credible evidence suggesting that he did those things. For that reason alone, Dr. Gaeta is not guilty of this alleged standard-of-care violation. Further, the failure to obtain informed consent is a disciplinable offense under section 466.028(1)(o) and thus is not punishable under section 466.028(1)(x), which defines the separate offense (dental malpractice) that Dr. Gaeta has been accused of committing.[11] For this additional and independent reason, Dr. Gaeta cannot be found guilty of the standard-of-care violation alleged in A5.

34. As just mentioned, providing dental services without first obtaining the patient's informed consent is an offense punishable under section 466.028(1)(o). Dr. Gaeta was not charged pursuant to that statute. Moreover, presenting treatment options, explaining risks and benefits, and obtaining informed consent do not justify the course of treatment; doing

them does not transform an improper diagnosis into a correct one, nor does failing to do them deprive dentally necessary treatment of justification. Dr. Gaeta is not guilty of the recordkeeping violation as charged in B5.

35. Contrary to the allegations in A6, the evidence shows that Dr. Gaeta provided a diagnosis for tooth #29 which supported his determination that the tooth might be saved with a crown. The evidence is undisputed that replacing the filling was not a reasonable option; the only alternative treatment was extraction. The evidence fails to establish that Dr. Gaeta was required, in meeting minimum standards of performance, to determine why the amalgam filling came loose from tooth #29. The evidence fails to prove that Dr. Gaeta was unaware of the location of the filling in tooth #29; to the contrary, there is credible evidence that he dislodged the loose filling while probing it. Dr. Gaeta is not guilty of the standard-of-care-violation alleged in A6.

36. The notes and materials in R.S.'s chart justify Dr. Gaeta's treatment of tooth #29. No more than that is legally required. Dr. Gaeta is not guilty of the recordkeeping violation alleged in B6.

37. There is credible evidence that Dr. Gaeta provided post-operative instructions to R.S. In light of such evidence, the allegation that he failed to do so, as charged in A7, is not

established by clear and convincing proof. Dr. Gaeta is therefore not guilty of this alleged standard-of-care violation.

38. While the failure to give post-operative instructions might in some circumstances be shown to fall below minimum standards of performance, the failure to record in the patient's chart the giving of such instructions does not make an appropriate course of treatment unjustified, any more than giving——and noting in the record the giving of——post-operative instructions would justify an inappropriate course of treatment. The purpose of section 466.028(1)(m) is not to ensure that every dentist-patient communication is noted, every tool or instrument used listed, all actions taken, however routine, described in detail; nor is it to obligate the dentist to defend in writing his every diagnosis, treatment decision, exercise of professional judgment, and therapeutic act against potential criticism, as a sort of preemptive rebuttal to a possible future malpractice claim. Rather, the statute is designed, more modestly, to ensure that patient records contain information showing that every course of treatment has a rational basis in dentally relevant facts. Dr. Gaeta was not legally required to document his discussions with R.S. regarding post-operative instructions, and therefore he is not guilty of the recordkeeping violation as alleged in B7.

39. The evidence shows that Dr. Gaeta used an apex locator to measure the canal length of R.S.'s tooth #9. Consequently, the allegation in A8 that he failed to do so is not established by clear and convincing evidence. Dr. Gaeta is not guilty of this charge.

40. R.S.'s record contains X-rays and reflects the fact that Dr. Gaeta determined the canal length of tooth #9. The minimum statutory requirements were satisfied with respect to these particulars. Dr. Gaeta is not guilty of the recordkeeping violation alleged in B8.

41. There is credible evidence, which the Department failed sufficiently to overcome, showing that Dr. Gaeta used a rubber dam when he performed a root canal on R.S. Thus, the evidence is not clear and convincing that he failed to use this common dental implement, as alleged in A9. Dr. Gaeta is not guilty of this alleged standard-of-care violation.

42. Section 466.028(1)(m) does not demand that a patient's record reveal that the dentist used common dental tools in the customary fashion. If the statute were held to require that level of detail, the dentist would need to note, e.g., the routine use of scalers and currettes, periodontal probes, latex gloves, drills, etc.——an absurd result. Therefore, although Dr. Gaeta did not document the use of a rubber dam, he was not

legally required to do so. Dr. Gaeta is not guilty of the recordkeeping charge found in 9B.

43. The evidence shows that Dr. Gaeta diagnosed R.S.'s periodontal condition. The evidence does not clearly and convincingly establish any minimum standards of performance that Dr. Gaeta failed to meet, under the facts of this case, in addressing the periodontal condition. As a result, Dr. Gaeta is not guilty of the standard-of-care violation alleged in A10.

44. The evidence shows that Dr. Gaeta made a determination regarding tooth #29's ability to support a crown. He is therefore not guilty of the standard-of-care violation charged in A11.

45. The evidence shows that Dr. Gaeta made a determination concerning the cause of tooth #29's collapse. He is therefore not guilty of the standard-of-care violation charged in A12.

46. It is undisputed that Dr. Gaeta did not record in R.S.'s chart the type and amount of anesthetic used during the root canal procedure. Dr. Gaeta contends that producing local anesthesia with Septocaine® is not "treatment" and therefore need not be noted in the dental record. This argument is rejected; the use of medicine to control pain and anxiety is surely a form of "treatment" as that term is commonly used and understood. Consequently, section 466.028(1)(m) requires that the patient record contain justification for the use of anesthetic agents,

which means that the drugs and dosages administered must be documented.[12] Dr. Gaeta is guilty of the recordkeeping violation charged in B13. He has, moreover, been found guilty of, and been disciplined for, recordkeeping violations on two previous occasions.[13]

47. Credible evidence, which the Department failed rebut with clear and convincing evidence, shows that Dr. Gaeta took X-rays of R.S.'s tooth #9 before initiating root canal therapy. The X-rays and other information in R.S.'s chart justified that course of treatment. The allegations in B14 are not supported by clear and convincing evidence, and thus Dr. Gaeta is not guilty of this alleged recordkeeping violation.

48. The evidence does not demonstrate clearly and convincingly that Dr. Gaeta performed any thermal, pulp, or bite percussion tests before initiating root canal therapy. Therefore, he cannot be punished for failing to record in R.S.'s chart the results of such tests, as charged in B15. Dr. Gaeta is not guilty of this alleged recordkeeping violation.

CONCLUSIONS OF LAW

49. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569, and 120.57(1), Florida Statutes.

50. A proceeding, such as this one, to suspend, revoke, or impose other discipline upon a license is penal in nature.

State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Accordingly, to impose discipline, the Department must prove the charges against Dr. Gaeta by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996)(citing Ferris v. Turlington, 510 So. 2d 292, 294-95 (Fla. 1987)); Nair v. Dep't of Bus. & Prof'l Reg., Bd. of Medicine, 654 So. 2d 205, 207 (Fla. 1st DCA 1995).

51. Regarding the standard of proof, in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the court developed a "workable definition of clear and convincing evidence" and found that of necessity such a definition would need to contain "both qualitative and quantitative standards." The court held that:

> 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 testimony 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 a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Id. The Florida Supreme Court later adopted the Slomowitz court's description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District

Court of Appeal also has followed the Slomowitz test, adding the interpretive comment that "[a]lthough this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991), rev. denied, 599 So. 2d 1279 (Fla. 1992)(citation omitted).

52. Disciplinary statutes and rules "must be construed strictly, in favor of the one against whom the penalty would be imposed." Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); see Camejo v. Dep't of Bus. & Prof'l Reg., 812 So. 2d 583, 583-84 (Fla. 3d DCA 2002); McClung v. Crim. Just. Stds. & Training Comm'n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984)("[W]here a statute provides for revocation of a license the grounds must be strictly construed because the statute is penal in nature. No conduct is to be regarded as included within a penal statute that is not reasonably proscribed by it; if there are any ambiguities included, they must be construed in favor of the licensee."); see also, e.g., Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929 (Fla. 1st DCA 2011)(statutes imposing a penalty must never be extended by construction).

53. Due process prohibits an agency from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument. See §

120.60(5), Fla. Stat. ("No revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of a final order, the agency has served, by personal service or certified mail, an administrative complaint which affords reasonable notice to the licensee of facts or conduct which warrant the intended action . . . ."); see also Trevisani v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005)("A physician may not be disciplined for an offense not charged in the complaint."); Marcelin v. Dep't of Bus. & Prof'l Reg., 753 So. 2d 745, 746-747 (Fla. 3d DCA 2000); Delk v. Dep't of Prof'l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992)("[T]he conduct proved must legally fall within the statute or rule claimed [in the administrative complaint] to have been violated.").

54. In Count I of the Complaint, the Department charged Dr. Gaeta under section 466.028(1)(m), which provides in pertinent part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action . . . :
>
> * * *
>
> (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.

55. In connection with this charge, the Department alleged further that Dr. Gaeta had not complied with rule 64B5-17.002, which provides, in relevant part, as follows:

> **64B5-17.002 Written Dental Records; Minimum Content; Retention.**
> (1) For the purpose of implementing the provisions of subsection 466.028(1)(m), F.S., a dentist shall maintain written records on each patient which written records shall contain, at a minimum, the following information about the patient:
> (a) Appropriate medical history;
> (b) Results of clinical examination and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases;
> (c) Any radiographs used for the diagnosis or treatment of the patient;
> (d) Treatment plan proposed by the dentist; and
> (e) Treatment rendered to the patient.

56. The Department reads the statutory phrase, "justifying the course of treatment," to mean, in effect, "proving that the course of treatment met the standard of care."[14] Under the Department's interpretation of section 466.028(1)(m), the dentist must keep a detailed diary of all his interactions with the patient, writing a narrative that includes, among other things, a record of dentist-patient communications; an explication of the dentist's analysis of (and rationale for) each treatment choice; an explanation of why alternative treatments were rejected; and a list of instruments used. Patient records of the sort the Department envisions would be a

treasure trove of tempting targets for criticism, nit-picking, and second-guessing. It is therefore understandable that Department prosecutors——not to mention civil trial lawyers—— would appreciate having access to records containing such information. The Department frankly acknowledges, however, that its position depends on an expansive interpretation of section 466.028(1)(m), under which obligations not expressly stated in the statute would be imposed on the profession.

57. Therein lies the problem with the Department's position. The law requires that disciplinary statutes be strictly construed, not liberally expanded. Considering that even dentists who have been accused of committing malpractice do not have the burden to prove that they met the standard of care, it would be anomalous if the recordkeeping statute required all dentists routinely to create patient records sufficient in themselves to demonstrate the exercise of reasonable care under the circumstances.[15] Accordingly, unless and until the legislature enacts a statute clearly imposing such a recordkeeping burden, the minimum obligation under section 466.028(1)(m), narrowly construed, is to document information sufficient to show that the course of treatment had a rational basis in dentally relevant facts.[16]

58. As found above, the undersigned has determined that, with one exception, Dr. Gaeta created a patient record for R.S.

that conforms to the requirements of section 466.028(1)(m). Dr. Gaeta's failure to record the use of an anesthetic agent in connection with the root canal procedure constitutes the sole recordkeeping violation proved in this case. Although the Department proved just one recordkeeping deficiency, Dr. Gaeta's disciplinary history shows that he is a recidivist with regard to section 466.028(1)(m)——a fact that will affect the penalty recommendation which follows.

59. In Count II of the Complaint, the Department charged Dr. Gaeta under section 466.028(1)(x), which provides in pertinent part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action . . . :
>
> * * *
>
> (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.

60. As found above, the Department did not succeed in proving by clear and convincing evidence that Dr. Gaeta failed to meet the minimum standards of performance in treating R.S., as charged in the Complaint.

61. The Board of Dentistry imposes penalties upon licensees in accordance with the disciplinary guidelines prescribed in Florida Administrative Code Rule 64B5-13.005. The range of penalties for a third offense involving section 466.028(1)(m), which is set forth in rule 64B5-13.005(1)(m), is from probation with conditions and a $2,500 fine to revocation and a $10,000 fine.

62. Rule 64B5-13.005(2) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances are to be taken into account:

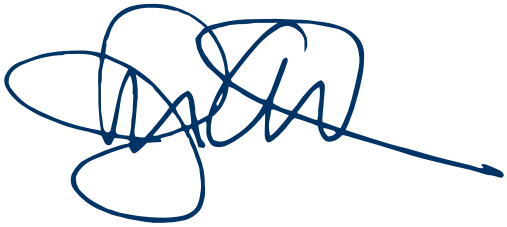
> (a) The danger to the public;
> (b) The number of specific offenses, other than the offense for which the licensee is being punished;
> (c) Prior discipline that has been imposed on the licensee;
> (d) The length of time the licensee has practiced;
> (e) The actual damage, physical or otherwise, caused by the violation and the reversibility of the damage;
> (f) The deterrent effect of the penalty imposed;
> (g) The effect of the penalty upon the licensee;
> (h) Efforts by the licensee towards rehabilitation;
> (i) The actual knowledge of the licensee pertaining to the violation;
> (j) Attempts by the licensee to correct or stop the violation or refusal by the licensee to correct or stop the violation; and
> (k) Any other relevant mitigating or aggravating factor under the circumstances.

63. Subparagraphs (a), (b), (d), (e) set forth relevant mitigating factors in this case, while subparagraphs (c), (f), (h), and (i) are aggravating factors. On balance, the undersigned does not find compelling reasons to deviate from the guidelines and therefore recommends that the Board of Dentistry impose a penalty that falls within the recommended range.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Dentistry enter a final order finding Dr. Gaeta guilty of the recordkeeping violation alleged in paragraph 27 l) of the Complaint (failure to record types and amounts of anesthetic agents used); finding Dr. Gaeta not guilty of the remaining violations; and imposing the following penalties: suspension from practice for three months, followed by probation for 18 months with conditions reasonably related to the goal of improving Dr. Gaeta's recordkeeping skills; and a fine in the amount of $2,500.

DONE AND ENTERED this 12th day of June, 2012, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 12th day of June, 2012.

ENDNOTES

[1]/ Petitioner's Exhibit 8 is the deposition of patient R.S., which was offered and received in lieu of his appearance and testimony at hearing.

[2]/ With one exception, the Department did not allege that Dr. Gaeta violated the recordkeeping requirements by failing to document that he did not perform a particular dental act.

[3]/ See, e.g., Brooks v. Serrano, 209 So. 2d 279, 280 (Fla. 4th DCA 1968)

[4]/ See § 466.028(1)(x), Fla. Stat.

[5]/ Brooks, 209 So. 2d at 280.

[6]/ See Robinson v. Fla. Bd. of Dentistry, Dep't of Prof'l Reg., 447 So. 2d 930, 932 (Fla. 3d DCA 1984)("One professional's opinion, without more, on a particular treatment is neither

substantial evidence of incompetence nor a measure of 'generally prevailing peer performance.'").

[7]/ The expert should not be permitted to testify on direct examination that his opinions regarding the standard of care were based on consultations with colleagues or other experts about the case, for that would improperly bolster the testifying expert's credibility while providing a conduit for inadmissible hearsay. See Linn v. Fossum, 946 So. 2d 1032, 1039 (Fla. 2006). An informed understanding of prevailing professional standards may be predicated, however, on the expert's own experiences in comparable situations; the experiences of other professionals as made known to him before the incident giving rise to the lawsuit; and professional principles, practices, and theories learned in school, or from technical literature, "shop talk," seminars, etc. Id. at 1040 n.5 (citing as distinguishable, and with apparent approval, Jefferis v. Marzano, 696 P.2d 1087 (Or. 1985)).

[8]/ Cf. B.B.A. v. Dep't of Health & Rehab. Servs., 581 So. 2d 955, 958 (Fla. 1st DCA 1991)(Zehmer, J., dissenting)(dissenting judge cogently explains that unless an expert's views are stated as being a reflection of the "generally accepted practice in the medical profession," his testimony regarding the standard of care "is effectively nothing more than his own personal opinion that may or may not be recognized generally").

[9]/ Because Dr. Gaeta was not charged with failing to retain patient records, which is a different shortcoming from that charged here, namely failing to put sufficient information in a patient's record, the Department's reliance on section 466.018(4)——dealing with record retention——is misplaced.

[10]/ See Trevisani v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005)(doctor could not be disciplined for failing to retain possession of patient records because administrative complaint alleged only that doctor had failed to create or complete the records).

[11]/ Cf. Barr v. Dep't of Health, 954 So. 2d 668 (Fla. 1st DCA 2007)(recordkeeping violations are not punishable as dental malpractice because there is a "significant difference" between the two, and treating recordkeeping deficiencies as standard-of-care violations would render "useless" the statute defining inadequate recordkeeping as a disciplinable offense).

[12]/ Reinforcing this conclusion is rule 64B5-14.006, which requires dentists to report adverse incidents arising from the use of anesthesia to the Board of Dentistry. Such reports must include, among other information, a "[l]ist of drugs and dosage administered." Fla. Admin. Code R. 64B5-14.006(c).

[13]/ See Dep't of Health v. Gaeta, Case No. 2003-05087 (Fla. Bd. of Dentistry Aug. 25, 2009); Dep't of Health v. Gaeta, Case No. 1999-61008 (Fla. Bd. of Dentistry Feb. 12, 2002).

[14]/ The Department does not articulate its position in these terms. It writes, instead, that "the detail [in the patient record] should be enough to protect the patient from harm . . . ." Pet.'s Prop. Rec. Order at 33. The undersigned interprets the Department's argument as an assertion that the patient record must be sufficiently detailed to show that the dentist protected the patient from harm, i.e., exercised reasonable care under the circumstances in accordance with the minimum standards of performance. Elsewhere in its Proposed Recommended Order the Department makes clearer its notion that the patient record must suffice per se to prove that the dentist met the standard of care. E.g., id. at 26 ("Because [the crown-to-root ratio] was not documented, [the administrative law judge] must conclude that the standard of care was not met and find that the Respondent did not meet the required minimum standard of care."); id. at 26-27 ("Petitioner is justified in assuming this lack of documentation[, i.e., the absence of a note in the patient record explaining why a crown was placed on tooth #29,] means the diagnosis was not done to support the treatment provided. This fails to meet the minimal standard in diagnosis and treatment."); id. at 29 ("The Respondent testified at trial that he used an apex locator, but he did not document this fact in writing. Therefore, [the administrative law judge] must find that he did not do so.").

[15]/ It is not an exaggeration to observe that the Department's interpretation of the recordkeeping statute, if adopted, would have a burden-shifting effect bearing on the standard of care. This is because the Department tacitly maintains that unless the patient record contains within its four corners evidence sufficient to show that the course of treatment met the minimum standards of performance, then the dentist is guilty——at least of a recordkeeping violation and probably of a standard-of-care violation as well.

[16]/ Of course, satisfying this minimum recordkeeping requirement does not necessarily produce proof that the minimum standards of performance were met; conversely, the failure to satisfy the minimum recordkeeping requirement, without more, is not proof that the minimum standards of performance were not satisfied. At bottom if a dentist is later charged with a standard-of-care violation, the patient record (whether in or out of compliance with section 466.028(1)(m)) is not the only evidence available to the Department on the question of whether the standards of performance were met. The Department can use other evidence to prove such a charge, just as the dentist can use other evidence in his defense.

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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