

BEFORE THE IOWA DENTAL BOARD

IN THE MATTER OF :)	
)	
DANIEL J. SCHUSTER, D.D.S.)	FINDINGS OF FACT,
902 S. 17 TH Street)	CONCLUSIONS OF LAW,
Oskaloosa, IA 525771)	DECISION AND ORDER
)	
License #7896)	
)	
Respondent)	

On January 10, 2008, the Iowa Dental Board (Board) filed a Notice of Hearing and Statement of Matters Charges against Daniel J. Schuster, D.D.S. (Respondent) charging him with:

Count I: Failing to maintain a satisfactory standard of competency in the practice of dentistry, in violation of Iowa Code section 153.34(8)(2007) and 650 IAC 30.4(16); and

Count II: Willful or repeated violations of Board rule by failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended for dentistry by the Centers for Disease Control of the United States Department of Health and Human Services (CDC), in violation of Iowa Code section 153.34(4)(2007) and 650 IAC 30.4(35).

Respondent filed an Answer on February 22, 2008. A hearing was initially scheduled for April 23, 2008 but was continued four times at Respondent's request. Respondent's fifth Motion for Continuance was denied. The hearing was held before the Board on April 14 and 15, 2009. The following members of the Board presided at the hearing: Deena R. Kuempel, D.D.S., Chairperson; Gary Roth, D.D.S.; Lynn Curry, D.D.S.; Eileen Cacioppo, D.H.; Valinda Parsons, D.H.; Elizabeth Brennan and Diane Meier, public members. Assistant Attorney General Theresa O'Connell Weeg represented the state of Iowa. Attorneys John C. Gray and Robert Gittleman represented Respondent. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was recorded by a certified court reporter and was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1) and 650 IAC 51.20(13).

Following the hearing, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f)(2009), to deliberate. The Board directed the administrative law judge to prepare their Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the Motions for Continuances, Resistances and Rulings; State Motion in Limine, Resistance, and Ruling Denying Motion in Limine; Respondent Application for Admission Pro Hac Vice and Order Granting Admission Pro Hac Vice; Respondent Motion in Limine, Resistance, Ruling Granting in Part, Denying In Part; Respondent's Motion in Limine filed 4/13/09, which was denied at the beginning of the hearing; testimony of the witnesses; State Exhibits 1-29 (See Exhibit Index for description); Respondent Exhibits 101-125 and 132-138 (See Exhibit Index for description of 101-124) Exhibit 125 was the curriculum vitae of Dr. Roger Druckman, Exhibits 132-135 were articles from dental journals, Exhibits 136-138 were ADA Parameters for treatment of pain of nondental origin and temporomandibular disorders.

FINDINGS OF FACT

1. Respondent was issued Iowa dental license number 7896 on June 17, 1997 and has practiced dentistry in Oskaloosa, Iowa since that time. Respondent is a general dentist who provides orthodontic services. He has approximately 5,000 patients in his general practice at this time. (State Exhibit 1; Respondent Exhibit 115; Respondent testimony)

2. Following licensure in 1997, Respondent developed an interest in temporomandibular disorders (TMD). The temporomandibular joint (TMJ) is located just in front of the ear. TMD is a musculoskeletal disorder which involves pain and dysfunction in the muscular system, in the joint system, or in a combination of the two. Patients may experience clicking or popping of the TM joint, which may be a sign of an alteration in the condyl/disc¹ relationship. However, clicking and popping without other symptoms are not necessarily a sign of pathology. Patients may also experience pain and dysfunction in the nervous system related to the head and face. The dysfunction may include limited ability to open the mouth, jaw locking in the open or closed position, or pain on chewing, speaking, swallowing, or yawning. (Testimony of Respondent; Board Consultant; H. Clifton Simmons III, D.D.S.; State Exhibit 28, pp. 27-28; State Exhibit 29, pp. 7-9)

Over the past eleven years, Respondent has completed more than 300 hours of continuing education in orthodontics, dental orthopedics, and TMD. In the spring of 1998, Respondent completed a 60-hour course entitled "Orthodontic Success," which was taught by John Witzig, D.D.S. Dr. Witzig's course addressed the connection between headaches and compression of the TM joint. Respondent subsequently provided Dr. Witzig's TMD treatment to a relative, who suffered from severe migraines, and her headaches slowly subsided and then disappeared. Respondent continued to attend courses in orthodontia and TMD treatment and began treating some of his

¹ The ball of any joint, including the TM joint, is referred to as the condyl. The disc is located between the condyl and the joint socket. (Simmons testimony)

patients for TMD. In 2004, Respondent completed thirty-hours of continuing education course work taught by Dr. Harold Gelb, which strongly influenced his current approach to treating TMD patients. (Respondent testimony; State Exhibits 11-C, 12)

3. BW, a former patient and former employee of Respondent, filed a complaint with the Board on February 1, 2007. BW was dissatisfied with the temporomandibular joint (TMJ) treatment that Respondent provided to her and questioned the propriety of some of his office procedures, including procedures for infection control. (State Exhibit 10; McCollum testimony)

4. The Board's investigator, Phil McCollum, went to Respondent's dental office on February 22, 2007 to serve a subpoena for BW's dental records and to conduct an infection control inspection. Respondent cooperated with Mr. McCollum during the visit. Respondent assigned his registered dental assistant, who was very familiar with the infection control protocols utilized at the office, to assist the Board's investigator during his inspection. Investigator McCollum used a checklist that is based on the Centers for Disease Control's (CDC) Morbidity and Mortality Weekly Report (MMWR), which provides Guidelines for Infection Control in Dental Healthcare Settings.² The investigator identified the following deficiencies in Respondent's office protocols:

- Employee immunization records were not on file.
- Dental handpieces were not sterilized between patients.
- Assistants did not have access to utility gloves while performing instrument cleaning.
- Some instruments (handpieces) were stored unwrapped/unbagged.
- Regulated medical waste was being disposed of in regular trash.
- Shelves & cabinets housing chemicals were not labeled.
- No OSHA eyewash station in the dental office.
- No job safety poster in the dental office.

When Mr. McCollum pointed out that the electronic handpieces had to be heat sterilized between every patient, Respondent replied that the sales representative who sold the electronic handpieces to him told him that they did not have to be sterilized between patients. A Board consultant later contacted a manufacturer and a supplier of electronic handpieces and confirmed that the handpieces must be removed from the base and heat sterilized. Respondent conceded at hearing that he likely misunderstood the instructions provided to him by the sales representative when he purchased the equipment in 2002. Respondent reports that he has a hearing loss stemming from his military service. (McCollum, Respondent testimony; State Exhibits 8, 9)

Respondent's dental office apparently had an eyewash station, but it was located in the basement and not readily available for use on patients. Respondent's staff had been

² Board rule 650 IAC 30.4(35) incorporates the CDC guidelines as the standard precautions that dentists are required to follow.

using ordinary gloves, not thicker utility gloves, for disinfecting instruments. Respondent immediately corrected these and all other deficiencies cited in the investigator's report. (Respondent, McCollum testimony)

5. In his letter to the Board and in his testimony at hearing, Respondent explained his TMD treatment philosophy and approach. Respondent fabricates a lower acrylic orthotic (also referred to in the record as a splint and as an anterior repositioning appliance or "ARA"), which is designed to place the jaw into or as close as possible to the "Gelb 4/7 position." This may advance the mandible (lower jaw), increase vertical dimension, balance out an upper cranial base asymmetry, and/or cause distal placement of the condyle. The orthotic initially covers all of the patient's lower teeth and is to be worn 24 hours a day, seven days a week. Respondent considers the proper location of the jaw to be that position which relieves the patient's symptoms of pain and dysfunction. (Some of the witnesses have referred to this as Phase I of the TMD treatment.)

Once the proper jaw position is established using the orthotic, Respondent determines what options are available to permanently correct and stabilize the patient's jaw joint by correcting the patient's occlusion to the new jaw position. (This has been referred to as Phase II of the treatment) The available options depend on the particular patient but may include continued use of the orthotic with periodic resurfacing of the units, placement of a permanent anodized bite restoring partial, crown and bridge work, an overlay partial, or orthodontics. When the orthodontic option is used and brackets are placed on the patient's teeth, Respondent gradually cuts the back portion of the patient's orthotic to allow the back teeth to be brought together in proper occlusion.

Respondent states that he only provides treatment to patients whose TMD symptoms cannot be managed or resolved through exercise, relaxation techniques, stress reduction, weight loss, bilateral chewing, dietary changes, massage therapy, chiropractic care, limited oral medications or physical therapy. Respondent estimates that TMD treatment constitutes approximately 1% of his practice. He further estimates that he has had a 90% success rate in relieving the symptoms of the patients he has treated for TMD. (Respondent testimony; State Exhibit 11-C)

6. After he was served with the subpoena, Respondent was allowed to gather and submit BW's dental records to the Board by mail. These records did not include Respondent's pretreatment model for BW, which was produced for the first time on March 9, 2009. As a result, none of the state's expert witnesses knew that the pretreatment model existed when they reviewed Respondent's records and submitted their opinion reports. Respondent's explanation was that he stored pretreatment models in the basement of his office and it did not occur to him to provide it with the rest of the records.

Respondent first saw BW in January 2002 for a tooth extraction. At a visit on May 6, 2004, BW filled out a patient history form answering yes to questions asking whether

she ever experienced jaw clicking or pain (joint, ear, side of face). Respondent's record for the visit does not provide any further documentation of the patient's symptoms and does not specify whether BW had pain in her joint, her ear, the side of her face, or all three. He does not document the severity or duration of the symptoms. He does not document whether any other interventions or treatments had been attempted previously. Respondent's notes for this visit indicated that the patient has a class 2 Div 1 malocclusion, that he discussed an option to restore proper function of her jaw, and that he gave her the treatment option and a plan. The record did not include a written treatment plan. The note indicated that the patient would get back to Respondent when she made a decision. (State Exhibit 15-A, p. 1 of 4) On September 1, 2005, Respondent's note states:

“check occl, POI, POC sat, took impressions and radiographs of the TMJ and pt desires the repair of function and correction of the joint space, discussed financials at length and pt agrees with treatment.”

The note further indicates that he did a “wax bite try in.” (State Exhibit 15-A, p. 3 of 4). On September 13, 2005, Respondent examined BW and partially completed a 7-page Orthodontic Examination form. The form documents information concerning the patient's dentition, dental screening, and arch soft tissue and jaw. The form indicates that Respondent had the following diagnostic records for the patient: bitewing, cephalometric, full mouth series, panoramic x-rays, photographs, TMJ examination, and transcranials. The “study models” box does not appear to be checked. The “Treatment Plan” section of the form is not filled out. Under “Adjunctive Recommendations,” Respondent states “at next visit we will do a lower appliance. Then when her jaw is inline we will expand upper & lower with brackets and place bridges on the upper where teeth #5 & #12 are missing (gave tx plan for bridges)” Treatment time was estimated at 18 months depending on jaw healing. Under “Fee Discussion,” Respondent indicated that the cost of the treatment was \$4000 and detailed his payment agreement with the patient. (State Exhibit 15-A)

After a second wax bite try-in on September 14, 2005, Respondent determined that BW's jaw was in a good position and sent the wax bite off to have a TMD orthotic fabricated. On October 11, 2005, Respondent placed the orthotic in the patient's mouth but did not document the visit in the patient record until October 14th. The October 14th note stated that Respondent “instructed her on the care and use of the orthotic”, including the importance of wearing the orthotic while eating. Respondent told BW to call if she developed a sore spot and to keep a diary of her symptoms as treatment progresses.

BW returned to Respondent's office on October 14th for an orthotic adjustment because it was making her tongue sore. According to Respondent's note, BW was happy with the fit, and she told Respondent that she felt great, her back ache had stopped, she had stopped snoring, and she had not had any headaches. At her dental appointment on November 15, 2005, BW reported that she was very happy with the way she felt, her legs

were the same length, her hips no longer had any pain, and she had no headaches or neck pain. On November 23, 2005, Respondent placed brackets on BW's upper and lower 6 teeth, placed elastics, and cut out the orthotic. BW returned on January 18, 2006. Respondent's note stated that the teeth were erupting nicely, and she should return in 4 weeks to have the orthotic adjusted and brackets placed on the lower to erupt. Over the next several months Respondent continued to make adjustments to the orthotic, brackets, and elastics. By September 26, 2006, Respondent's note indicates that the patient's premolars were touching. In October 2006 brackets were added to the lower #4 teeth. (State Exhibit 15-A, Patient Notes Master)

Respondent also sent the Board a written explanation and documentation of BW's employment. Respondent hired BW to work as a receptionist in his dental office in October 2006, but terminated her employment for misconduct two months later on December 11, 2006. At the time of termination, Respondent gave BW the option of having her TMD treatment completed at no cost to her or filing for unemployment benefits. BW initially elected to have Respondent complete her TMD treatment for free but later filed for unemployment and asked to have her dental records transferred to an orthodontist. (Respondent testimony ; State Exhibit 15-A)

7. In January 2007, BW went to a general practitioner for a second opinion and then filed her complaint with the Board. In her complaint, BW stated that all of her bottom teeth were loose and more crowded in the front than when she began TMD treatment with Respondent. She further complained that her bottom molars were "tipped over" to the inside of her mouth and her jaw joint was not seated. (State Exhibit 10) The general dentist performed a detailed TMJ Disorder evaluation of BW, and his exam revealed that BW had an anterior openbite with highly mobile lower anterior teeth. He told BW to discontinue the orthotic (splint) that Respondent had given her. He gave BW a full coverage splint, but it was discontinued because she could not tolerate it. He referred BW to a physical therapist, an ENT, and an orthodontist for further evaluation. He also recommended orthodontic care and orthognathic surgery with mandibular advancement to correct BW's dental occlusion. In April 2007, the orthodontist evaluated BW, found that she had a class II malocclusion with 2mm openbite and 7 1/2 mm overjet. His recommended treatment plan was removal of two teeth, comprehensive orthodontics, and surgical mandibular advancement. (State Exhibits 3, 15-B, 15-C)

8. The Board issued a second subpoena to Respondent on April 26, 2007, requesting complete original patient records and radiographs as selected by the Board's investigator. (State Exhibit 24) The Board's investigator served the subpoena and asked Respondent to select and provide the records for approximately ten of his TMD/TMJ patients. He allowed Respondent to collect the patient records and mail them to the Board. Respondent and/or his staff selected the records of eight patients and wrote their names on the Board's subpoena. Respondent also prepared a written "case study"

summary of his treatment for each patient at the time he produced the records.³ Respondent provided TMD treatment to seven of the additional eight patients that consisted of an orthotic (splint) to be worn 24 hours a day, 7 days a week followed by Phase II treatment consisting of orthodontics (brackets with vertical elastics to extrude the teeth) or dentures. Respondent gave one of the eight patients (MR) a removable expansion appliance to expand the upper arch 7-9 mm and open his airway. Afterwards, the patient's remaining teeth were removed, and complete upper and lower dentures were placed. (McCollum, Respondent testimony; State Exhibits 8-A, 16-23)

9. Respondent's case study summaries include information about the patient's condition and their treatment that cannot be found in the patient's records. Respondent's explanation for this discrepancy was that he makes "mental notes" on patients, which he is able to recall without contemporaneous supporting documentation because he does not have a large number of TMD patients and knows them all so well. (Testimony of Respondent)

10. The Board sent Respondent's dental treatment records for BW and the 8 additional TMD patients for review by a Board consultant. The consultant, an orthodontist practicing in Des Moines, issued a written report on October 9, 2007. (State Exhibits 2, 3) He summarized Respondent's TMD treatment regimen as using an anterior splint to position the mandible downward and forward and then placing orthodontic brackets in order to attach vertical elastics to extrude the teeth to capture the mandible in the splint induced position. He noted in his report that many of Respondent's cases lacked pretreatment or post treatment study models and orthodontic treatment plans. In most cases, the consultant was not able to see the patient's bite before, during or after treatment. He noted that Respondent took numerous joint films and that all of the patients had a diagnosis of compressed joint space. The consultant testified that it is very difficult to diagnose TMD due to a lack of accepted or standard criteria. He was unable to offer an opinion as to whether Respondent's diagnoses of the patients were valid.

The Board consultant testified that many TMD symptoms resolve without any treatment at all. He has often treated patients with symptoms of clicking or joint pain by recommending a low salt diet, ice or heat, relaxation techniques, referral to a physical therapist, or a simple permissive splint that allows teeth to move and is worn only at night. He stated that there are many different types of splints available and that the evidence has not shown that the type of treatment provided by Respondent is more effective than conservative short term use of a permissive splint. The Board consultant was very skeptical of claims that Respondent's TMD treatment could resolve chronic

³ The Respondent provided the pretreatment study model for BW and some additional records (orthodontic examination forms, CD images of radiographs, study models, etc.) for the other eight patients to the Board on March 9, 2009, after all of the state's experts had already reviewed Respondent's records and provided written opinions. Respondent has not provided a satisfactory explanation for why he did not produce these records in 2007. (See Respondent Resistance to Motion in Limine for a listing of the additional records provided on March 9, 2009)

orthopedic conditions or back problems. In the consultant's opinion, Respondent's treatment was either inappropriate or unnecessary and was potentially damaging by adversely affecting the patients' occlusal scheme. He questioned the long term stability of the treatment and believed that many of the cases would significantly relapse due to the limited orthodontic treatment and extrusion mechanics used.

With respect to patient MR, the Board consultant testified that it is impossible to expand the maxilla of a person in their 50's using an appliance because the patient has no growth potential. The consultant ultimately concluded that Respondent lacks understanding of the fundamental orthodontic principles necessary to manage treatment in these cases by dramatically altering joint relationship and occlusion. In his opinion, the standard of care is conservative, reversible therapy for TMD. (Consultant testimony; State Exhibit 3)

11. Respondent also agreed to have his cases reviewed by another dentist with expertise in TMD and agreed to undergo personal assessment at the request of the reviewing dentist. Respondent assumed all costs of this further review. On July 8, 2008, the Board forwarded Respondent's patient records to Ales Obrez, D.M.D., Ph.D. Dr. Obrez is an associate professor of restorative dentistry at the University of Illinois (Chicago) College of Dentistry who has completed post-doctoral work in orofacial pain. Dr. Obrez' academic colleague, Gary Klasser, D.M.D., also reviewed Respondent's patient records. They chose not to personally contact Respondent as part of their review.

Drs. Obrez and Klasser ultimately concluded that Respondent's TMD treatment philosophy is not current, is "somewhat unfounded," and has led to occlusal discrepancies requiring fixed orthodontic treatment. In their opinion, the reliable literature contradicts the condylar displacement theory as the etiology of TMD. They believe that the current consensus in the literature is that the outcomes from conservative, reversible approaches to treatment are equivalent to the outcomes from invasive, irreversible approaches and therefore most TMD cases should be treated with conservative, reversible procedures. (State Exhibits 28, 29) They provided a bibliography of the authorities that they relied upon in reaching these opinions (State Exhibit 25) but copies of the authorities and articles were not submitted into the record and were not reviewed by the Board. Both Drs. Obrez and Klasser admitted that they were not familiar with any specific standard of care in Iowa .

In addition to their overall disagreement with Respondent's TMD treatment philosophy and approach, Drs. Obrez and Klasser offered the following additional criticisms:

- Respondent started patients on TMD treatment without first documenting an appropriate evaluation in the record to establish that the treatment was necessary. Proper evaluation and diagnosis should include patient interview, review of patient complaints, extraoral and intraoral examination, manual examination and cancer screening, appropriate radiographic examination and

utilization of proper radiographic modalities. (Exhibit 28, p. 10 ; Exhibit 29, p. 11, 63)

- In some cases, Respondent failed to document any symptoms requiring treatment, such as pain or dysfunction. (e.g. Patient CW, Exhibits 17, 28, pp. 66-77, Exhibit 29, pp. 35-37, 58-61; Patient DG, Exhibits 21, 28 pp. 87-89, Exhibit 29, pp. 42-43)
- Respondent failed to document a differential diagnosis, his explanation to the patient of available alternate treatments, or treatment consent forms . (HG, Exhibit 28, pp. 74-75; JE, pp.84-86; Exhibit 29, p. 20)
- Respondent inappropriately relied on panoramic and transcranial radiographs to determine the presence or absence of TMD. Drs. Obrez and Klasser cited the limitations of these types of imaging and believed that Respondent should have referred the patients for MRIs or CT scans. (Exhibit 28, pp. 78-81, 96; Exhibit 29, p. 13; 26-27, 51-54; Klasser testimony)
- Respondent failed to record in the chart what type of orthotic he placed and what instructions were given to the patient. (Exhibit 29, pp. 24, 32, 40) Both Drs. Obrez and Klasser agreed that a full coverage orthotic has much less risk and potential for adverse effects than a partial coverage appliance. (Exhibit 28, p. 67; Exhibit 29, p. 40)
- Respondent's belief that oral appliance therapy and orthodontics may have an effect on many other distant body parts, such as the back, legs, and hips is not supported by the literature. (Exhibit 29, pp. 9-10; 44-45)

(State Exhibits 4-6, 28, 29; Respondent Exhibits 116-117; Klasser testimony)

12. BW is the only patient who has expressed dissatisfaction with the TMD treatment provided by Respondent. Respondent presented testimony from four patients and affidavits from two additional patients whose TMD treatments were reviewed by the expert witnesses. All six patients expressed complete satisfaction with the symptom relief that they have experienced following their TMD treatment. (DG, HG, JE, SDH testimony; Respondent Exhibits 109, 110)

13. Respondent offered the testimony of two expert witnesses, both of whom provide two-phase TMD treatment similar to the treatment provided by Respondent. These expert witnesses explained this TMD treatment approach in detail and provided copies of dental journal articles, textbook excerpts, and American Dental Association (ADA) parameters to support their treatment protocols and their opinions. (Druckman, Simmons testimony; Respondent Exhibits 119-124; 132-138)

a. Roger Druckman, D.D.S. currently practices dentistry in Colorado. He has significant training and experience in TMD treatment and has presented lectures concerning TMD treatment both in the United States and abroad. From 1984-2004, 95% of Dr. Druckman's practice was TMD related. Since 2004, 50% of his practice is TMD related and 50% is general dentistry, including implantology. (Druckman testimony; Respondent Exhibit 125) Dr. Druckman disagreed with and disputed the

conclusions of the state's experts. In his opinion, Respondent provided excellent treatment, which was well within the standard of care, in all of the cases that were reviewed. Dr. Druckman disagreed with Drs. Obrez and Klasser's criticisms of Respondent's use of transcranial radiographs as part of his assessment and evaluation process and noted that the ADA parameters (Respondent Exhibit 132) and Okeson's widely used textbook on TMD and Occlusion (Respondent Exhibit 133) support the use of transcranial radiographs. Dr. Druckman opined that Respondent's charting was adequate because the records were sufficient for Respondent to recall what he had done and to continue treatment. Dr. Druckman gives all patients written instructions for wearing appliances (orthotics) and also puts the instructions in the patient record. However, he does not believe that the standard of care requires inclusion of the instructions in the patient record.

Dr. Druckman disagreed with state's experts' opinions that the persuasive literature supports the conclusion that TMD patients who are provided conservative treatment obtain substantially the same result as those who have more aggressive treatment. Dr. Druckman agreed, however, that some patients with minimal TMD symptoms may recover without any intervention and that it is necessary for the dentist to look at the patient's history and duration and severity of symptoms prior to instituting treatment. When Dr. Druckman evaluates a patient to determine if TMD treatment is appropriate, he takes a complete patient history, uses a questionnaire to document the patient's relevant signs and symptoms, takes panoramic and transcranial radiographs, lateral head films, and photographs, and constructs a pretreatment study model. He palpates the patient's head, neck, and shoulder muscles, checks range of motion, and uses a Doppler ultra sound to listen to the patient's joint sounds.

b. H. Clifton Simmons III, D.D.S. has been an Assistant Clinical Professor at the Vanderbilt University Medical School Department of Dentistry in Nashville, Tennessee from 1993 to the present. He has also maintained a dental practice for 22 years specializing in Craniofacial Pain and TMD. (Simmons testimony; Respondent Exhibit 111) Dr. Simmons made a power point presentation to explain his TMD research and his TMD treatment approach, which is consistent with Respondent's treatment approach. He reviewed the nine patient cases at issue in this hearing and concluded that Respondent's treatment of the patients was competent and within the standard of care. He felt it was unfair for Drs. Obrez and Klasser to evaluate Respondent's treatment of BW as substandard when she left in the middle of treatment and did not complete it. In his opinion, the treatment Respondent provided to BW up to the time she left his practice was within the standard of care. Dr. Simmons further testified that all of the TMD treatment approaches, except surgery, are reversible.

In Dr. Simmons opinion, Respondent's charting was adequate. Although Dr. Simmons writes down all significant symptoms reported by the patient in his charts, he still felt that Respondent's records met the minimum standard of care. Dr. Simmons disagreed with Drs. Obrez and Klasser's criticisms of Respondent's use of transcranial radiographs and also pointed to Okeson's textbook as supporting the use of transcranial radiographs.

In addition, Dr. Simmons knew of no dentist providing TMD treatment who documented a differential diagnosis for each patient in the chart, as recommended by Drs. Obrez and Klasser.

CONCLUSIONS OF LAW

Count I: Failure To Maintain a Satisfactory Standard of Competency In The Practice of Dentistry

Iowa Code section 153.34(8) (2007) and 650 IAC 30.4(16) authorize the Board to discipline a licensed dentist for failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry. Count I alleges that Respondent failed to maintain a satisfactory standard of competency in the practice of dentistry because he:

- a. Provided TMD/TMJ treatment to nine patients that was inappropriate, unnecessary, and which caused potential long term damage to dentition;
- b. Lacks an understanding of fundamental orthodontic principles necessary to treat these cases;
- c. Uses a treatment approach that can adversely affect the patient's occlusal scheme;
- d. Uses a treatment approach that is likely to result in significant relapse because its long term stability is questionable;
- e. Inappropriately claimed to reverse chronic orthopedic conditions with short-term dental splint wear.

The Board has carefully reviewed the evidence presented, including the patient records, the conflicting opinions of the expert witnesses, and the various published authorities submitted into the record. The Board has also considered Respondent's testimony and the testimony and affidavits of the patients who experienced significant pain relief and/or significant improvement in function following Respondent's TMD treatment. After weighing the evidence, the Board was unable to conclude, by a preponderance of the evidence, that Respondent's two-phase TMD treatment approach falls below the minimum standard of care ordinarily exercised by Iowa dentists under similar circumstances or that his approach adversely affects patient's occlusal schemes or is likely to result in significant relapse.

Respondent presented persuasive expert testimony and dental journal articles to support the conclusion that his use of the two-phase TMD treatment satisfies the minimum standard of care for dentistry when it is properly utilized in appropriate cases. Based on the patient testimony and affidavits, it does appear that Respondent has had significant success in relieving patients' pain and dysfunction with his TMD treatment. BW has not had satisfactory results from her TMD treatment, however the Board is reluctant to rely on her case when Respondent's treatment was interrupted at a crucial juncture and then terminated after Respondent fired BW for allegations of misconduct.

The preponderance of the evidence, however, did establish that Respondent failed to maintain a satisfactory standard of competency because he did not individually and carefully evaluate each patient to ensure that the TMD treatment he proposed was necessary and appropriate for them. All of the experts agreed that TMD treatment is only justified if the patient's quality of life is adversely affected due to symptoms of pain and or dysfunction. Some of the nine patients had no symptoms documented that would justify the complex TMD treatment that they were provided. At a minimum, Respondent should have fully documented the patient's history and should have described the location, severity, triggers, and duration of any reported pain. Respondent should also have documented any dysfunction reported by the patient, including jaw locking, limited opening, or difficulty chewing. Respondent should also have documented what other less aggressive treatments or techniques had been utilized in an attempt to relieve the symptoms and the results, if any, of these treatments.

Respondent should have developed and maintained an appropriate and complete diagnostic record for each patient, including pretreatment and posttreatment study models, cephalometric radiographs, and photographs, in addition to panoramic and transcranial radiographs. However, the Board was not persuaded that MRIs or CT scans are required prior to instituting treatment. Respondent must document all of his clinical findings during his physical examination of the patient, including findings on palpation of the jaw joint. Respondent must document a diagnosis for each patient that is based on the patient history, clinical findings, and diagnostic record. The Board was troubled by the fact that each patient had an identical diagnosis. Respondent must have a written treatment plan and must document and describe the orthotic provided to the patient and the instructions that he gave the patient concerning its use.

Respondent's explanation that he performed the necessary evaluations but that he had this information stored in his memory was neither satisfactory nor credible. Respondent's later produced case summaries for the patients, when he knew his care was under scrutiny, do not satisfy the requirement for contemporaneous documentation. Although Respondent may be very familiar with his TMD patients, it is impossible for him to retain all of the pertinent information in his head when he has a caseload of approximately 5000 patients. Moreover, if Respondent becomes unable to continue caring for one or more of these patients for any reason, it would be impossible for another dentist to assume competent care of these complicated patient cases without adequate documentation in the patient record.

The Board was dismayed that Respondent provided additional records for these patients more than a year after the subpoena was issued to him and after the state's experts had already reviewed the cases. It was Respondent's obligation, not the obligation of his staff, to comply with the subpoena. Moreover, Respondent should have understood the importance of providing all of his records to the Board, including study models, when he knew the Board was reviewing whether his TMD treatment satisfied competency standards. The state's experts were left to review the cases submitted to them based on partial and incomplete records. The fact that many of the later produced records were

not contemporaneously dated further complicated the Board's review and makes it difficult to accord them much weight.

Count II: Failure to Comply with Standard Precautions Related To Infection Control

Iowa Code section 153.34(4) (2007) authorizes the Board to discipline a licensed dentist for willful or repeated violations of Board rules. 650 IAC 30.4(35) authorizes the Board to discipline a licensed dentist for failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

The preponderance of the evidence established that Respondent violated Iowa Code section 153.34(4)(2007) and 650 IAC 30.4(35) through repeated failures to comply with standard precautions for preventing and controlling infectious diseases. The Board's investigator credibly documented a number of deficiencies at Respondent's dental office, including failure to clean and heat-sterilize critical dental instruments between patients and before each use, failure to provide puncture and chemical-resistant utility gloves for instrument cleaning and decontamination procedures, failure to have an eyewash station in the dental treatment area of the office, and failure to post a job safety and health protection poster. Respondent promptly corrected all of these deficiencies.

Of these, the most serious deficiency was the failure to heat sterilize removable electronic high speed hand pieces between patients. Respondent does not deny that he failed to properly sterilize the hand pieces but explained that he misunderstood the instructions provided by the sales representative when he purchased the equipment. Respondent failed to recognize that he needed to remove the hand piece from the electronic base and heat sterilize it. The Board does not believe that Respondent purposefully failed to sterilize the hand pieces. Nevertheless, the violation was ongoing and repeated from 2002 until the inspection on February 22, 2007. During that time, Respondent exposed numerous patients to risks of contamination and infection. Consistent with prior Board precedent, the nature and seriousness of this violation merits the imposition of sanctions.

DECISION AND ORDER

THEREFORE, IT IS HEREBY ORDERED that Respondent Daniel J. Schuster, D.D.S. is CITED for repeatedly failing to comply with standard precautions for preventing and controlling infectious diseases and is hereby WARNED that further violations of the statutes and rules governing the practice of dentistry could result in further disciplinary action against him, including suspension and revocation.

IT IS FURTHER ORDERED that License no. 7896, issued to Respondent Daniel J. Schuster, D.D.S., shall be immediately placed on probation for a period of five (5) years

from the date of this Order. Upon successful completion of 36 months of probation, the Respondent may ask the Board for early termination of the probation. While under probation, the Respondent shall be subject to the following terms :

1. Respondent shall pay a civil penalty in the amount of one thousand two hundred dollars (\$1,200) within sixty (60) days of the date of this Order for the violations under Count II.
2. Respondent shall complete a Board approved course in infection control during the 2009-2010 biennium.
3. Respondent shall successfully complete a board approved course in recordkeeping within ninety (90) days of the date of this Order.
4. Respondent shall successfully complete the dental assistant infection control examination within sixty (60) days of the date of this Order.
5. Respondent shall ensure that all staff members who perform infection control duties in his office pass the Iowa dental assistant infection control examination within sixty (60) days of the date of this Order.
6. Respondent shall submit quarterly reports to the Board detailing compliance with the terms and conditions of this Order. Respondent shall ensure that the reports are submitted prior to the first day of January, April, July and October of each calendar year.
7. Respondent shall maintain a log of all patients that he treats for TMD and shall submit the log with his written quarterly reports to the Board. The records of these TMD patients will be subject to random review by the Board or Board consultants for compliance with the standard of care.
8. Respondent shall fully cooperate with random, unannounced visits by agents of the Board .
9. Respondent shall be responsible for all costs associated with compliance with this Order, and shall also be responsible for all costs incurred by the Board in the monitoring of this Order to determine compliance. Respondent shall promptly remit one hundred (\$100.00) dollars for these costs on or before the first day of January, April, July, and October of each year while on probation.
10. Respondent shall upon reasonable notice, and subject to the provisions of 650 Iowa Administrative Code 31.6, appear before the Board at the time and place designated by the Board.

11. Periods of residency outside the state of Iowa may be applied toward probation if approved by the Board prior to the commencement of the out of state residency. Notice of any change of residence must be provided to the Board within fourteen (14) days of the change.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 650 IAC 51.35(2) that the Respondent shall pay \$75.00 for fees associated with the disciplinary hearing and any costs calculated by the executive director and attached to this Order, within thirty (30) days of receipt of this decision.

Dated this ^{29th} day of *April*, 2009.

Deena R. Kuempel, D.D.S.

Deena Kuempel, D.D.S.
Chairperson
Iowa Dental Board

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Judicial review of the board's decision may be sought in accordance with the terms of Iowa Code chapter 17A and Iowa Code section 153.33(4)(g) and (h).