BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE HEARINGS
ON REFERRAL BY THE BOARD OF DENTAL EXAMINERS

In the Matter of:	)	
	)	
DOUGLAS G. NESS, D.D.S.,	)	
	)	
Respondent.	)	OAH No. 04-0250-DEN
	)	Board No. 1200-02-016

Decision and Order

I. Introduction

This is a licensing case before the Board of Dental Examiners under AS 08.36 in which the Division of Corporations, Business and Professional Licensing seeks to discipline Dr. Douglas Ness. The division's accusation contains allegations that Dr. Ness performed a surgical procedure on a patient, R.R., with attendant complications, and that his dentistry efforts did not meet minimum professional standards under AS 08.36.315(6) and were unethical under AS 08.36.315(7) and 12 AAC 28.905. Dr. Ness requested a hearing.[1] The case is governed by provisions of the Administrative Procedure Act (APA).[2]

Based on the evidence from the hearing, the following counts were proven. Under Counts I, II, and III, Dr. Ness violated AS 08.36.315(6) because his performance of surgery on R.R. and his post-operative treatment did not conform to minimum professional standards. Ness's treatment was unnecessary and the patient was not an appropriate candidate for the surgery (Count I). The surgery was performed in a manner that fell below minimum standards of performance in the field of dentistry (Count II). In addition, Dr. Ness's aftercare for R.R. fell below minimum standards of performance when Ness failed to timely refer his patient to an appropriate specialist when the need arose (Count III).

Under Count VI, Dr. Ness violated AS 08.36.315(6) because his performance of surgery on R.R. and his post-operative treatment of R.R. violated ethical standards. Dr. Ness violated the ethical principle of nonmalfeasance, imposing on him the duty to "do no harm" to a patient,

[1] The case was originally filed as an appeal to a Department of Commerce, Community and Economic Development (DCCED) hearing officer. The Office of Administrative Hearings (OAH) was created under AS 44.64.010 in 2004. A transitional provision transferred the hearing officer for DCCED to OAH.
[2] AS 44.62.330-.640.

because the surgery was unnecessary, it was performed incompetently, Ness was not qualified to perform the surgery, and he failed to timely refer R.R. to an appropriate specialist. The remaining counts were dismissed by stipulation.

The following sanctions are appropriate: (1) that Dr. Ness be suspended from the practice of dentistry for four months, (2) that he pay a combined fine of $20,000, with $5,000 suspended, for violations as alleged in four counts of the accusation that were proven, (3) that Ness participate at continuing education for eight hours on ethics before resuming active practice, and (4) that his license be subject to probation for a period of five years after the preceding conditions are fulfilled during which time his office records will be subject to a random audit by the board or its designee in each of the probation years.

II. Procedural Matters

A hearing took place over a period of six days. The hearing record consists of nineteen audiocassette tapes, with the vast majority comprised of testimony from eight dentists who testified about the dental surgery at issue. Two attorneys represented Dr. Ness and an assistant attorney general represented the division. The following witnesses testified at the hearing under oath and subject to cross-examination in the sequence indicated:

1. Frederick Reinbold, D.M.D., M.D.
2. Katie Julien, D.D.S., M.S.
3. David Dana, D.D.S.
4. Charles Michael, D.D.S.
5. Richard Younkins
6. Sterling Schow, D.M.D
7. R.R. (The patient upon whom Dr. Ness performed surgery)
8. Diane Murray
9. William Parks
10. Cheryl Richardson
11. Mary Marshall
12. Jean Sampson
13. Warren Mitchell, D.D.S.
14. Deborah Stewart
15. Kimberly Hall
16. Benson McGann, D.D.S.
17. Douglas Ness, D.D.S.

The exhibits listed below have been admitted as evidence in this proceeding.

Division's Exhibits

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17, 18, 19, 20, 22, 23, 26, 27

Dr. Ness's Exhibits

A, B, D, J, K, N, O, T, U, W, X, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AK, AL, AM, AN, AO, AP, AQ, AR, AS, AT, AU, AV, AW, AX, AY, AZ, BA, BB, BC, BD, BE, BF, BG, BH, BI, BJ, BK, BL, BM, BN, BO, BP, BQ, BR, BS, BT, BU, BV, BW, BX, BY, BZ, CA, CB

Dr. Ness offered exhibit AA at the end of the hearing without explaining the purpose for which it was offered. The division's objection to its admission is sustained.

Exhibit AE was referred to at the hearing as one exhibit including all pages identified AE through CA. To avoid confusion, AE is a one-page exhibit as marked, with subsequent attached exhibits marked as indicated through Exhibit CA.

Dr. Ness objected to Dr. Schow, the division's expert, referring to patients of Dr. Ness other than R.R. The objection was sustained. This Decision and Order does not rely on evidence from Dr. Schow relating to a patient other than R.R. Dr. Ness nonetheless referenced a patient of his other than R.R., and that patient is briefly referenced in this decision based on evidence from Dr. Ness.

The motion deadline in this case was September 5, 2005. At the hearing, before the division completed its case, Dr. Ness made an oral motion to dismiss all of the counts in the accusation and to stay the proceeding based on the division allegedly not producing all of Dr. Reinbold's records and, as a consequence, depriving his expert, Dr. Dana, of an adequate opportunity to prepare his testimony. The division denied any misconduct. Dr. Ness was given the opportunity to file a written motion on the matter. He agreed that he would file a written motion, but he did not do so. Insofar as the oral motion was not withdrawn it is denied because Ness failed to meet his burden of demonstrating that it was well taken.

Dr. Ness also made an oral motion at the conclusion of Dr. Reinbold's examination to exclude Reinbold's testimony. Ness did not believe that Reinbold, an oral surgeon who did not practice general dentistry, should testify about the standard of care in the case. He also made reference to an alleged prior inconsistent statement by Dr. Reinbold, although no documentation was presented to prove the existence of such a statement. By agreement, Ness was given the opportunity to file and brief a written motion. Thereafter, Ness's counsel made no filings on the issue. Ness therefore appears to have abandoned the contention in his oral motion. To the extent the oral motion was not withdrawn, it is denied for lack of support and for the reasons discussed in Part IV-A. Reinbold's testimony was admissible under AS 44.62.460(d).

On March 22, 2006, Dr. Ness filed a motion to disqualify the administrative law judge, later submitting an affidavit in support of the motion. The motion was denied in an order issued April 6, 2006. The order explains the reasons for denial. On April 7, 2006, Dr. Ness filed substantially the same motion again. The April 7 motion is likewise denied.[3]

III. Facts

Dr. Ness has been licensed to practice general dentistry in Alaska since 1989. He has operated his own clinic in Anchorage, Aesthetic Dental Arts, since 1999.

Dr. Ness began providing R.R. with basic dental care beginning on July 13, 2000. R.R. "had a history of periodontal disease with bone loss and thin attached tissue in the lower incisor region."[4] R.R. had crowding of upper and lower teeth, including anterior teeth 22-27. R.R. also had class II malocclusion, with the lower jaw set back, resulting in malposition and imperfect contact of the mandibidular and maxillary teeth. Dr. Ness recommended orthodontics at his first meeting with the patient. In August 2000, Ness placed a gingival graft in anticipation of orthodontics. R.R. received braces from Ness in April 2001.

Dr. Ness discussed other treatment options with R.R. in 2000-2002, including the option of doing nothing and the option of extracting two teeth to make room for others. He also discussed two options for "surgically assisted orthodontics" that involved skeletal changes instead of just realignment of teeth.

One surgical option that Ness recommended as treatment for R.R. was that he undergo orthognathic surgery. This surgery of the bones to change the skeletal relationship of the jaw is performed by an oral surgeon, who is a dental specialist. Total surgery-related expenses approximate $20,000, and the procedure has risks attendant with undergoing general anesthesia and cutting bone in the jaw. The variety of orthognathic surgery that Ness suggested to R.R. was a segmental osteotomy to be performed by Dr. Thomas Wells, an oral surgeon in Alaska.[5] Although R.R. saw Dr. Wells in early 2001, he ultimately decided that he did not want

[3] Because this case was pending before the effective date of AS 44.64.070 and is therefore not governed by that statute, AS 44.62.450(c) controls the handling of the disqualification motions. That statute assigns the decision on the motion to the sitting hearing officer, and does not authorize a decision by or appeal to the Chief Administrative Law Judge. Other procedural options available to Dr. Ness were explored in a letter from the Chief Administrative Law Judge to his counsel dated March 25, 2006. The letter can be found as an attachment to the April 6 order on disqualification.

[4] Exhibit B.

[5] Exhibit 4, p. 100014. According to Ness's chart note for February 22, 2001, "Dr. Wells said that he did not see how Dr. Ness could do the [orthodontics] without the [orthognathic] surgery." Exhibit A, pp. 100006.

orthognathic surgery. His decision was based primarily on the cost, since his dental insurance carrier denied coverage and R.R. apparently could not afford the surgery at the time.

The other surgical procedure Dr. Ness suggested was "a new procedure called segmental mandibular osteotomy."[6] The surgery was intended to lengthen the jaw. Ness described it to R.R. in March 2001.[7] It is this procedure that he ultimately performed.

Dr. Ness learned the surgery procedure he performed on R.R. from attending a Progressive Orthodontic Seminar (POS) for general practitioners in the fall of 2001. The basic seminar was held in Orange County, California, and ran for twelve four-day periods (Friday through Monday) over a two-year period. Dr. Ness also attended the Advanced Series in 2001, involving five more trips to Orange County.[8] He told the division's investigator on December 13, 2002:

> So, during the time I had been, you know, that previous year, you know, the year, you know, 2001 and even before, in my training, and then in the fall of 2001, in some of the continuing ed courses and where I – the, the group that I studied with and, I study orthodontics, we were introduced to a, a procedure or a concept of procedures, there were a lot of different procedures, that could be used to allow the teeth to be moved further than they normally could without conventional jaw surgery where we actually move the whole jaw forward . . . and that's what we call the corticotomy procedures.[9]

Although lower labial corticotomy, the type of surgery Ness later performed, was one of six types of corticotomies addressed in the seminar, corticotomies in general were just "one small part" of the seminar and lectures.[10] The only time that there was a specific corticotomy topic in the POS program was in the advanced series, in the first of five seminars, which took place in 2001.[11]

Dr. Ness did not have hands-on experience with patients at POS to learn the surgical procedure he performed on R.R. He mainly listened to lectures. Although Ness told the division's investigator (while Ness's counsel was present) that Ness taught POS training for "a

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[6] Exhibit 5 (emphasis added). An undated orthodontic diagnostic worksheet in Ness's records for R.R., likely from 2000 dental treatment, also references a "palatal" corticotomy as an option under "surgically assisted orthodontics." Exhibit 4, p. 100024.

[7] Id.

[8] Exhibit O.

[9] Exhibit 17, p. 000063. See also Cross-exam of Ness (advanced POS program in fall 2001 introduced Ness to application of lower labial mandibular corticotomy; "Prior to that we were hearing little things in the application of it in dentistry" [emphasis added]).

[10] Cross-exam of McGann.

[11] Exhibit O. According to Dr. Ness, the American Dental Association certified POS courses.

couple years,"[12] Dr. Ness later testified under oath at the hearing that he did not teach POS training.

After receiving this instruction, Dr. Ness told R.R. that "he had received specialized training" and "had received extensive experience on how to perform the osteotomy procedure."[13] Ness stated to R.R. that he could perform the surgery. He said the osteotomy would give the same alignment of teeth as orthognathic surgery, and the procedure would be preferable to leaving the teeth alone. Ness also told R.R. that his osteotomy procedure was superior to orthognathic surgery. R.R. wrote that "Ness was quite relentless in telling me the osteotomy procedure was the way to go" to correct the malocclusion. He said that Ness "worked hard to convince [me] to have the osteotomy."[14]

Risks for the corticotomy Dr. Ness performed include loss of teeth, loss of bone, gingival recession, sloughing ("dehiscing") of the flap with necrosis, and incomplete bite correction.[15] R.R.'s later complications included all of these. The informed consent form authorizing R.R.'s surgery did not fully address potential complications for this surgery.[16] R.R.'s dental condition was compromised to begin with due to a history of periodontal disease, a gingival graft and pre-existing bone loss. A reasonable patient would want to know about the potential complications from the surgery, including the possibility of gum recession, flap failure, and bone loss.[17] Because he did not know about these risks, R.R. did not receive enough information to make an informed treatment choice.[18]

Ness performed the surgery once between learning about it at POS and performing it on R.R. On June 6, 2002, Dr. Ness performed the surgery on R.R. The $950.00 fee billed to R.R. was significantly less expensive than the $20,000 total estimated expenses for orthognathic surgery. That, along with Ness's representations and assurances, created incentives for R.R. to undergo the surgery.[19]

Dr. Ness and the seven other dentists who testified used a wide variety of nomenclature to describe R.R.'s surgery. Insofar as this may lead to confusion, it is attributable in part to the

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[12] Exhibit 17, p. 000086.
[13] Exhibit 5; Exhibit 17. Ness had performed palatal expansions before R.R.'s surgery.
[14] Exhibit 5, p. 1100011.
[15] Direct exam of Dana.
[16] Exhibit 4, p. 100008.
[17] Cf. Harrold v. Artwohl, ___ P.3d ___, Supreme Court No. S-11638 (March 31, 2006)(in the context of a non-emergency appendectomy, addressing informed consent and what a reasonable patient might want to know).
[18] *See, e.g.,* Exhibit 5, pp. 1100013-14 (R.R.'s 2002 complaint letter).
[19] Cross-exam of Ness.

fact that the surgery involved more than one procedure. The terms corticotomy and osteotomy both involve cutting bone. The division, Dr. Ness, and some witnesses often referred to the procedure with the general term corticotomy, a broad term that includes any cutting of the cortical bone and would include, for example, wisdom tooth extractions. Documents in Dr. Ness's patient file for R.R. identify the procedure before surgery both as "lower osteotomy" and "corticotomy (lower labial)."[20] After the surgery, Ness described the surgery using other terms. He called it a mandibular segmental osteotomy, but he also submitted a dental insurance claim form for "corticotomy of mandible" "to allow for rapid advancement (distraction osteogenesis)."[21] Ness's letter to Dr. Katie Julien dated September 13, 2002, refers to corticotomy and rapid advancement of the mandible.[22] His letter to the Board of Dental Examiners dated June 5, 2003, refers to his "distraction osteogenesis surgery."[23] Ness also repeatedly referred to the procedure generally as "surgically-assisted orthodontia." R.R. described the surgery as mandibular segmental osteotomy, based on what Ness had told him.[24] Dr. Julien stated corticotomy in this context is "typically called distraction osteogenesis." The division's expert, Dr. Schow, referred to the procedure as "distraction osteogenesis surgery."[25] Ness's expert, Dr. Dana, referred to the surgery as "rapid advancement corticotomy," an orthodontic procedure. Another Ness expert, Dr. McGann, referred to the surgical procedure at issue generally as "surgically-assisted orthodontics," but he also referred to it as lower labial corticotomy. In his expert report, McGann was asked to opine on Dr. Ness's "corticotomy and osteogenesis technique." Dr. Reinbold, an oral surgeon, referred to R.R.'s surgery as an osteotomy in his chart notes. Dr. Remaklus, a periodontist, referred to the procedure both as an osteotomy and as a corticotomy.[26] Remaklus testified that on August 28, 2002 Dr. Ness told him that he performed buccal and lingual corticotomies.

Based on the evidence, the administrative law judge finds that Dr. Ness performed a corticotomy on R.R.'s anterior mandible for the purpose of correcting malocclusion. After the corticotomy, Ness attempted distraction osteogenesis. The surgery also constituted an attempted

[20] Exhibit 4, pp. 100002, 100008.
[21] Exhibit 4, p. 100020-21; Exhibit 12, p. 100130.
[22] Exhibit B.
[23] Exhibit 1.
[24] Exhibit 5.
[25] Exhibit 16.
[26] Exhibit 26.

mandibular segmental osteotomy.[27] So far as the witnesses at the hearing were aware, Ness is the only dentist licensed in Alaska who has performed the surgery at issue.[28]

The first part of the procedure on R.R. included creating flaps, sections of re-positioned soft tissue. The procedure for making a flap involves cutting the gingiva and rolling it back, and then putting it back in place near the end of the surgical procedure. Creation of a flap by surgical incision allows access to underlying tissues. "[A]ll areas of the flap must have a source of uninterrupted vasculature to prevent ischemic necrosis of the entire flap or portions of it."[29] Creation of a flap is common in the practice of general dentistry.[30]

To make the flaps, Dr. Ness used a bur instrument to make horizontal and vertical incisions on both buccal and lingual (cheek and tongue) sides. Vertical incisions were made between teeth 21-22 and 27-28. The preponderance of the evidence showed that the bur "clearly was too wide an instrument to be going between two teeth without damaging them."[31] The medullary bone was not cut through, although it may have been partially cut. Dr. Remaklus expressed that he thought Ness "went though more than just the cortical bone," that is, the cut may have gone into the medullary bone.[32] Dr. Julien thought that Dr. Ness may have cut into the medullary bone.

The evidence in this case establishes that Ness de-vascularized the bone (cut off the blood supply) of the segment he created containing teeth 22-27. In the process of making the flaps, Dr. Ness also accidentally lacerated the roots of teeth 21 and 28 with the bur.[33]

In the next stage of the procedure, the section of incised mandible with teeth 22 through 27 was separated (distracted) from the posterior mandible in an attempt to advance the section forward. Chart notes indicate that on the day of the surgery, Dr. Ness cemented an advancing screw appliance to the sectioned bone and teeth on both sides of the mandible, to be used starting

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[27] This decision uses quotes from witnesses at the hearing reflecting the broad nomenclature used to describe R.R.'s surgery.

[28] Ness described it to Dr. Katie Julien as a "revolutionary procedure," and he provided her written materials along with a website address discussing the surgery. Ness stated that "because the corticotomy procedures are not well done, well known, or recognized in the United States – they have been in the past, it's kind of come out of favor, it's done well in Europe and Asia – I thought it would be reasonable to share what I had learned." Ness gave copies of literature from the POS courses to Drs. Julien, Remaklus, and Reinbold.

[29] Exhibit CB, pp. 156-157.

[30] Direct exam of Dana.

[31] The quotation is from Dr. Schow; Dr. Reinbold testified similarly.

[32] Exhibit 26.

[33] Dr. Ness acknowledged in his letter to the division, during his interview with the division's investigator, and at the hearing, that he caused the lacerations to R.R.'s tooth roots.

about a week after the surgery.[34] The appliance was intended to allow R.R. to manually advance the section forward at home each day and gradually facilitate bone regeneration (osteogenesis) where the vertical incisions were made.

During the investigation, Dr. Ness stated that he placed the expansion appliance five days after the surgery.[35] In fact, his own chart notes, consistent with R.R.'s recollection of the day surgery occurred, indicate that the expansion appliance was cemented on the day of surgery.[36] Ness acknowledged in his chart notes that the advancement may have been too rapid.[37]

Complications soon developed with R.R.'s labial flap. Within days, he noticed gum loss and exposed bone in the lower anterior area. The weekend after surgery, R.R. called Dr. Ness and complained about it. Ness saw R.R. for a post-operative check-up on June 12, 2002.[38] That day, he advised R.R. to begin advancing the appliance 3-4 mm (15 cranks) per day. R.R. also saw Dr. Ness on June 19, 24, and 27, 2002. R.R. pointed out the gum recession and exposed bone to Ness on many occasions that month. Ness did not seem worried about it according to R.R., and he assured R.R. "everything is going to be ok." In contrast, Ness's chart notes indicate "labial bone exposed below incisors. Probably too rapid advancement" (June 17); "labial gingiva still sloughed" and "May need hyperbaric O_2 in healing" (June 19); and "Lower ant. Wound still bone exposed, but area appears to be getting pink color"(June 24). R.R.'s labial flap sloughed and gum receded,[39] exposing tooth roots and alveolar processes.

Due to the complications, Ness had slowed the expansion appliance advancement to "2 cranks per day" on June 17. R.R. stated that Ness told him to completely stop turning the appliance and that "we let things sit for two more weeks." Dr. Ness does not have a chart entry for advising R.R. to stop turning the appliance.[40] The administrative law judge finds that Ness advised R.R. to stop cranking the appliance at some point after June 17, 2002, and before June

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[34] Exhibit 4, p. 100006; Exhibit 5, p. 1100011. Excerpts from Dr. Ness's chart notes covering R.R.'s surgery and aftercare are attached to this decision.

[35] "I didn't put the appliance on right that day. I think a few days later we put – we had to put the expansion appliance on – in about five days or so." Exhibit 17, p. 000073. Because the distraction osteogenesis part of the surgery was time sensitive, Ness's misstatement related to a significant issue. Ness stated later in his interview with investigator Younkins that he put the appliance in on the day of surgery. Exhibit 17, p. 1000090. The interview was conducted with Ness's counsel present.

[36] Cross-exam of Ness; Exhibit 4, p. 100006; Exhibit 5, p. 1100011.

[37] June 17, 2002, chart note.

[38] Exhibit 4, p. 1000006. Ness's chart indicates that he saw R.R. for the first time after surgery on June 17, 2002. The chart is incorrect, as Ness testified "I did fail to make an entry there." Dr. Schow's report notes "I see no evidence of 'operation reports' that are routinely part of the medical records for more major medical procedures. Dr. Ness's records are scanty regarding the details of surgery." Exhibit 16.

[39] Drs. Ness, Dana and Remaklus referred to the flap "dehiscing."

[40] The lack of a chart note for this important event is troubling.

24, 2002. On June 27, 2002, Ness removed the expansion appliance at R.R.'s request due in large part to R.R.'s complaint about the awkwardness of the apparatus.[41] Immediately upon removing the appliance, black tissue with gum recession and bone loss were evident in the lower anterior area."[42] Dr. Ness first raised with R.R. the possibility of hyperbaric treatment that day in order to facilitate healing. To de-mobilize teeth in the segmented section after removal of the expansion appliance, Ness made a splint consisting of rigid wires anchored to R.R.'s molars and cemented to teeth between the molars on both tongue and facial sides.[43]

Dr. Ness prescribed hyperbaric oxygen treatments in an attempt to heal R.R.'s anterior mandible area. Beginning June 28, 2002, the day after the expansion appliance was removed, R.R. received daily sessions for twenty consecutive days at a total cost of around $40,000.[44] Ness initially sought to have R.R.'s insurer pay for the treatments, but when coverage was denied, he paid for the treatments himself.

In July 2002, while undergoing hyperbaric treatments and being evaluated by Dr. Ness about twice a week, R.R. repeatedly asked Ness to refer to him to a specialist.[45] Dr. Ness responded that R.R. should wait for further healing to occur. In the meantime, however, R.R. made his own appointment to see a specialist.[46] On July 23, 2002, orthodontist Dr. Katie Julien examined R.R. Her staff took photos of his teeth. Julien noted that she had requested R.R.'s dental records from Ness's office and all the records were not provided to her.[47] Upon examining R.R., she observed extreme bone loss in the anterior mandible area.[48] She concluded that Ness's surgery had not corrected the malocclusion and that the four most posterior teeth on one side were not pushed forward. Also, the anterior teeth in the mandible were proclined at a slant that would not sustain normal occlusal forces.[49]

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[41] R.R. continually complained about the expansion appliance after the surgery. Cross-exam of Ness.
[42] According to R.R., "Once the advancing appliance was removed [June 27] Dr. Ness noted the loss of gum tissue and started to tap dance about the recovery process."
[43] Exhibit 7, p. 1100104.
[44] Although the receded gums were healing, they would not increase. Ness conceded at closing argument that in the end, they "weren't able to quantify how much [the treatments] helped." Closing of Ness.
[45] In Dr. Ness's interview with the division's investigator, Ness stated that R.R. was insistent that he "wanted to go to a specialist." Exhibit 17, p. 000080. Ness referred R.R. to periodontist Dr. Matthews, a colleague, on July 25, 2002. (Exhibit 4, p. 100016) A few days later, on August 5, 2002, R.R. and his wife demanded that Ness refer him to a specialist for treatment at their last meeting. Exhibit 4, p. 100004.
[46] R.R.'s wife made the appointment on his behalf.
[47] Dr. Ness eventually hand-delivered some of his dental records for R.R. to Julien on September 13, 2002, along with a letter to her. The letter states that R.R. "had a history of periodontal disease with bone loss and thin attached tissue in the lower incisor region." Ness's pre-surgery records for R.R. were never provided to Julien.
[48] Exhibit 7, pp. 1100106-107.
[49] Id. at 1100110.

Dr. Julien referred to the surgery Dr. Ness performed as a distraction osteogenesis, which included a corticotomy followed by the use of an appliance to move the bone segment. The surgical procedure Ness performed on R.R. was improper in her opinion. While she disagreed that orthodontics involves cutting of bone ("not something that is taught in universities that I am aware of"), she emphasized that alignment of teeth through orthodontia should occur before bone is cut. Julien stated that a dentist faced with a need for treatment outside his expertise is required by the code of ethics to refer the patient to a specialist. In her opinion, as soon as the area of bone in the anterior of R.R.'s mouth sloughed off after surgery, Dr. Ness should have referred R.R. to a specialist for evaluation.

On July 23, 2002, after seeing Dr. Julien earlier that day, R.R. was evaluated by periodontist Dr. Greg Remaklus. He called in oral surgeon Dr. Frederick Reinbold, who worked nearby, to the evaluation. Remaklus and Reinbold told R.R. that he was in danger of losing eight teeth and that tooth 28 should be extracted immediately due to lacerated roots. The tooth was cut so badly that its potential decay and infection jeopardized bone in the chin and decreased the likelihood that other teeth in the segment would survive.

Eventually, on July 25, 2002, Dr. Ness agreed to refer R.R. to Dr. Robert Matthews, a periodontist. This was seven weeks post-surgery. After evaluating R.R., Dr. Matthews noted in an August 9, 2002, letter to Dr. Ness that there was 60% bone loss with complete loss of keratinized tissue on the facial side and granulated tissue around the gingival margin.[50] "[I]t would not be possible to regenerate any significant amount of bone around the involved teeth, nor could soft tissue grafting be expected to produce any significant coverage." Matthews recommended waiting two months for further healing by R.R.[51] Dr. Matthews did not review x-rays or measure the teeth for mobility, although reportedly x-rays of some type were taken on June 6, June 27, July 15, and July 29, 2002.[52] He did not testify at the hearing.

By the end of July 2002, at R.R.'s request a team of dentists in Anchorage was attempting to provide restorative treatment. The team included Dr. Charles Michael (general dentistry), Dr. Katie Julien (orthodontist), Dr. Greg Remaklus (periodontist), and Dr. Frederick

[50] A small amount of gingival healing was taking place. Direct and cross of Julien, Exhibits 7, 26. The amount of healing could not be quantified. Ness closing.
[51] Exhibit 4, p. 100015. Matthews' letter to Ness after the referral (exhibit 15) was referenced by the parties, but it was not introduced as evidence. However, Exhibit 4, p. 100015 from Ness's records is Dr. Matthews' letter to Ness, and it was admitted as evidence. References to Dr. Matthews in the division's closing argument that are not based on admitted evidence were disregarded.
[52] Exhibit 4, Exhibit I, Exhibit U, p. 700028.

Reinbold (oral & maxillofacial surgeon). According to R.R., the team dentists "were horrified" when they first looked at his mouth.

R.R. saw general dentist Dr. Charles Michael for evaluation on July 30, 2002.[53] Dr. Michael noted severe labial gingival recession with the gum receding down to the apex for teeth 22-27. "Teeth appeared to be overcorrected" with the tips of the lower front teeth end-to-end and the upper teeth at a proclined angle that caused extra-normal force on the lower teeth when they impacted.[54] Bone recession also was evident. Dr. Michael took x-rays. Teeth 21 and 28 had obvious root damage. He concluded that damage to the root of tooth 28 appeared to be a severe laceration from a dental procedure. Tooth 21 also appeared to have been lacerated during the surgical procedure, but he was less sure of that. His prognosis for tooth 28 was "hopeless" and it would have to be extracted. He thought the prognosis for tooth 21 was "guarded" and expected it too would need to be extracted, subject to confirmation by a periodontist. Dr. Michael's prognosis for teeth 22-27 was "poor" because of the loss of facial bone. He concluded R.R. had significant bone loss in the lower anterior mandible. "When you have that much bone loss, the bone isn't going to grow back."[55] In his opinion, the way the teeth were moved by Dr. Ness contributed to the bone loss.[56] According to Dr. Michael, even if the teeth were not extracted in 2002, in 5-10 years "they would have had to all been removed" because the bone loss would have continued.[57] Moreover, the aesthetics would not have been good.

When Dr. Michael evaluated R.R., he was familiar with distraction osteogenesis procedures used in medicine for surgery of the legs and other bone processes, but had no knowledge of it being used as a dental procedure.[58] Since that time, after learning about the procedure, he described the "degree of difficulty as high." He stated a dentist should assist hands-on before performing it alone, and not have training based solely on lectures. Based on this testimony and the weight of the other evidence, the administrative law judge finds that a

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[53] Exhibit 14.

[54] Although R.R.'s original occlusion was a class II, division I, Dr. Michael stated that when he saw R.R. on July 30, 2002, he had "class III occlusion." His posterior jaw relationship remained the same before and after Dr. Ness performed surgery.

[55] Dr. Remaklus also testified that R.R.'s bone would not grow back.

[56] According to Dr. Michael, proclination of the lower anterior teeth created pressure on the mandible bone that contributed to bone loss.

[57] Dr. Michael also testified "I think if we left the teeth the way they were [not extract], there is greater chance that the lingual [tongue side] bone would slowly recede away to match the bone on the facial. Because typically, the bone will tend to reach the same level." "I don't think it [waiting] would change the ultimate outcome." According to Dr. Michael, grafting soft tissue over the area would not work well because there would not be enough blood supply to that area.

[58] Dr. Michael referred to Ness's surgical procedure on R.R. as "anterior segment osteotomy." Exhibit 14.

dentist should have hands-on training experience before attempting the surgical procedure Dr. Ness performed on R.R.

Dr. Remaklus evaluated R.R. on July 31, 2002. Although he acknowledged that some gingival tissue was healing, Remaklus also noted "bone was dying" and "protruding through the gum." His chart note that day recognizes Dr. Matthews' advice to wait, but states "Dr. Michaels [sic] said to do whatever [periodontist Remaklus] says. I will discuss again with Dr. Reinbold, but I don't think 21, 28 will heal." Dr. Reinbold evaluated R.R. on August 2, 2002.[59] After removing the splint, he concluded that all the teeth in the segment had class III mobility and stated the teeth in the segment "were flopping around like piano keys."

R.R. obtained a third opinion on the need for extracting tooth 28 from an endodontist, Dr. Douglas Luiten. Dr. Luiten evaluated R.R. on August 6, 2002, and took x-rays. He concluded "Removal is advised."[60] Although there was disagreement between the team dentists, Dr. Ness, and Ness's dentist witnesses about the need to extract tooth 28 and the timing, the preponderance of the evidence supports a finding that it was necessary to extract the tooth and that the decision was not rushed. Ten weeks after Ness's surgery, tooth 28 was necrosed and non-restorable. The tooth also was "quite mobile" when Dr. Reinbold extracted it on August 23, 2002.

Dr. Ness visited Dr. Remaklus on August 28, 2002, to discuss his surgery on R.R. Ness told Remaklus that he "did buccal and lingual corticotomies and tried to move the teeth in block but got tipping instead."

Believing she had an ethical obligation under the code of ethics to report R.R.'s situation to the Board of Dental Examiners, Dr. Julien filed a complaint letter with the division on September 4, 2002, concerning Dr. Ness's dental treatment for R.R. On September 13, 2002, Dr. Ness hand-delivered a letter to Dr. Julien acknowledging that R.R. had chosen to complete his orthodontic care with Julien. Ness explained his treatment of R.R. to Julien, attempting to justify the surgery procedure and concluding that he thought R.R. would heal and recover well.[61] Ness characterized R.R.'s need for future treatment with Julien as "a straightforward orthodontic case at this point."[62] Dr. Julien disagreed.

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[59] Reinbold provided treatment to Ness on five subsequent occasions through December 2002.
[60] Exhibit 12, p. 1100131. Luiten's records (exhibit 13) were not introduced as evidence; however, his August 6, 2002, communication with Dr. Reinbold is part of Reinbold's records.
[61] Exhibit B.
[62] Id.

The Alaska team of dentists discussed a treatment plan for R.R., talking on the phone and also with some members meeting in person. They decided that it was not possible to restore teeth in the separated segment (22-27) due to their condition, as there was "greater than 50% bone loss." The team chose as its treatment plan removing the teeth as soon as possible to restore healing of the tissue and bone, and reconstruction to include bone grafting and placement of dental implants.[63] On December 5, 2002, teeth 21 through 27 were extracted. After the surgery healed, multiple bone grafts were placed in R.R.'s anterior mandible. Later in December 2002, R.R. received dental implants.

Although the team dentists and Dr. Ness's dentist witnesses disagreed about the need to extract teeth 21 through 27 and the timing for the extractions, based on the preponderance of the evidence the administrative law judge finds that it was appropriate to extract the teeth and that the extractions were not rushed.[64]

Dr. Ness's surgery on R.R. included the following surgical errors: using the wrong instrument, lacerating roots, bad flap design including making cuts that were too wide, too deep and too close to roots, and depriving the segment of blood supply.

R.R. eventually sought legal recourse against Dr. Ness. A civil settlement was reached concerning the dental treatment Ness provided R.R. While the exact terms of the settlement were not discussed, evidence disclosed at the hearing without objection established that Dr. Ness paid for $40,000 of hyperbaric treatment and also was responsible for all of R.R.'s restorative treatment, including teeth extractions, a bone graft, and placement of implants. Some of these expenses were reportedly covered by Dr. Ness's malpractice insurance.[65] R.R. testified that his dental outcome after restorative care ultimately was good, and he is very satisfied with his

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[63] The decision to extract teeth 21-28 was primarily Dr. Reinbold's as the oral surgeon, but Dr. Michael described the team's decision as "by consensus." Dr. Remaklus testified "it was my judgment that a good long term restorative plan would not retain the teeth." After evaluating R.R. on November 11, 2002, Remaklus concluded that "I didn't think that the bone loss or healing the bone loss was improving and I thought he was going to go downhill." "The six front teeth would not have survived on their own." Dr. Remaklus measured R.R.'s actual recession (or root exposure) on the teeth as ten millimeters. Based on the severe gum loss and irreversible bone loss, Remaklus advised Dr. Michael on November 12, 2002, four months after Ness's surgery, that he thought R.R. would lose teeth 21, 23, 24, 25, 26, and 27. The remaining tooth 22, the lower left cuspid, would be "of very limited value in a restorative treatment plan." Exhibit 26.

[64] Dr. Remaklus testified that 3-4 weeks is enough to wait for stabilization of gums and teeth. Exhibit 26, p. 45. According to Dr. Schow, removal of teeth 22-27 about six months after surgery had allowed enough time to wait and see the results of the healing process. Dr. McGann testified under cross-exam that it was not necessarily inappropriate for the Alaska team to extract R.R.'s teeth. Dr. Dana agreed that the team was correct to extract damaged teeth 21 and 28. R.R. concurred that the extractions were not rushed.

[65] Cross-exam of Ness.

appearance. According to R.R., Dr. Ness was partly responsible for this "because of the settlement."

After receiving Dr. Julien's complaint letter, the division commenced an investigation that eventually included taking statements from R.R. and Dr. Ness as well as hiring Dr. Sterling Schow as an expert. On December 30, 2003, the division issued an accusation seeking disciplinary sanctions against Dr. Ness.

IV. Discussion

This section of the decision includes the analysis and addresses the evidence as applied to counts in the accusation that were remaining at the end of the hearing. The accusation contains seven counts. Counts IV, V and VII were dismissed by stipulation of the parties before the completion of the hearing. Counts I, II and III allege that Dr. Ness's conduct "does not conform to minimum professional standards" in violation of AS 08.36.315(6). These counts will be addressed first in the remaining discussion, in sequence. The discussion then addresses Count VI, which alleges an ethical violation under AS 08.36.315(7) and 12 AAC 28.905(b). The final section of the decision addresses sanctions.

Because the division seeks to discipline an existing licensee, under AS 44.62.460(e)(1) of the APA the agency has the burden to establish violations alleged in the accusation by a preponderance of the evidence.

A. Determination of Minimum Professional Standards

Counts I, II and III are all based on alleged violations of AS 08.36.315(6) which provides that the board may discipline a dentist who

> Engaged in the performance of patient care . . . that does not conform to minimum professional standards of dentistry regardless of whether actual injury to the patient occurred.

Applying the above language, it will be necessary to establish the professional minimum professional standards[66] for dentistry in Alaska with regard to each of the three counts. Minimum professional standards in this case are set by dentists.[67]

This case presents the challenge of setting the professional standard for a procedure that some dentists characterize as experimental.[68] At one point, Dr. Ness described the surgery as a

[66] At many stages during the course of the hearing, both parties referred to "standard of care." The term appeared to have been used interchangeably with "minimum professional standards."
[67] Non-dentists may have input as well insofar as they sit on the Board of Dental Examiners. AS 08.36.010(a).
[68] Exhibit O.

new and "revolutionary procedure."[69] Dr. McGann, the general dentist who is the owner of POS[70] and the individual who instructed Ness in learning the surgery, stated in his report prepared in this case "Some may consider corticotomy to be experimental, especially if they have never done a case," but he also opined that "[w]e do not consider this procedure in any way experimental."[71] The more crucial inquiries about the surgery Ness performed are whether R.R. was an appropriate candidate for surgery, whether the procedures were performed competently, and whether, if properly performed, this method of treatment meets minimum professional standards of dentistry in Alaska. Dr. Ness pointed out no other dentist in Alaska does the surgery he performed on R.R.[72] Consequently, most witnesses at the hearing, including all the Alaska dentists other than Ness, did not have direct experience performing the procedure.

Dr. Ness objected to the division using orthodontists, endodontists, periodontists, and oral surgeons to testify about the standard of care for general dentistry. Under AS 08.36.247, however, a specialist in dentistry mush first be licensed as a general dentist. The testimony of Alaska specialists is therefore relevant to general dentistry. Unless excluded by an evidentiary ruling at the hearing, all of the testimony from dentists in this case was admitted under the broad standard of admissibility at AS 44.62.460(d).[73]

The board has authority to weigh conflicting evidence[74] and, under AS 08.36.315(6), to determine minimum professional standards for the dental profession in Alaska. Ultimately, the board is qualified to set Alaska's professional standards in this case.

B. Surgery Was Unnecessary and/or the Patient Was Not an Appropriate Candidate for Surgery (AS 08.36.315(6)) ***[Count I]***

Under Count I, the division argues that Dr. Ness's performance of surgery on R.R. did not conform to minimum professional standards of dentistry in violation of AS 08.36.315(6) because the surgery was unnecessary and/or R.R. was not an appropriate candidate for the

[69] Exhibit 17, p. 000082.
[70] Dr. Ness told the division's investigator that McGann is "strictly doing seminars," although he has an active dental practice outside the U.S. Exhibit 17, p. 000086.
[71] Exhibit O. According to Dr. McGann, corticotomy is "just one of the innovations I have done within the field of orthodontics." Cross-exam of McGann. Dr. Reinbold, an oral surgeon and an M.D., testified with regard to the surgical procedure Ness attempted (mandibular labial rapid advancing corticotomy) he had "never heard of that particular term."
[72] Exhibit 17, pp. 000095-96.
[73] Under the same broad standard, some latitude was extended to Dr. Ness in presenting his own evidence on minimum professional standards. Dr. Ness used as his experts two dentists who are not licensed in Alaska and have never practiced in the state.
[74] Halter v. State of Alaska, 990 P.2d 1035, 1040 (Alaska 1999).

surgery. The allegation that the surgery was unnecessary overlaps with Count VI. Dr. Ness argued at the hearing that he acted within the standard of care.

In determining whether the surgery was unnecessary and whether R.R. was an appropriate candidate for the surgery, the treatment options available to R.R. are relevant. Ness had advised R.R. that orthognathic surgery performed by an oral surgeon was the best treatment option. Removal of bicuspid teeth to make room for remaining teeth also was discussed. Another option Ness explored with R.R. was to do nothing. The option R.R. chose, surgery by Dr. Ness, was intended to correct malocclusion (bite), but also to improve his appearance. Excluding the option of orthognathic surgery, Ness felt his surgery "would have the best outcome, based on what I had seen and understood, and within [R.R.'s] financial constraints, and willingness to undergo some more minor oral surgery." Dr. Reinbold (oral surgeon) testified that a saggital split osteotomy with mandibular advancement was R.R.'s only option "in my practice," and he believed that "because that's the lowest risk procedure." Dr. Julien (orthodontist) stated that removal of teeth or sagittal split osteotomy of the lower jaw were possible approaches.

Despite his lack of Alaska licensure and practice experience in this state, Dr. Schow was the most persuasive dentist witness who testified at the hearing. Dr. Schow has taught oral surgery for over 25 years, the last two decades at Baylor College of Dentistry where he has been the Director of Residency Training since 1992. He is certified by the American Board of Oral and Maxillofacial Surgery. Dr. Schow is a frequent author, has published many professional articles, has contributed as editor of the oral and maxillofacial surgery section in the textbook Clark's Clinical Dentistry, and is a long time peer reviewer in the dental profession. Dr. Schow testified by videoconference and his demeanor was observable throughout his testimony.

Dr. Schow had never seen the type of surgery Ness performed on R.R. R.R.'s chief complaints were his bite and his appearance. Dr. Schow stated, "Moving the bone would do nothing to correct facial profile in the manner in which he was attempting to do so." Additionally, "there was no creation of space [by Ness] to move, to uncrowd the teeth." In his report to the division, Schow stated that "[t]here was nothing to be gained with distraction osteogenesis in this case, even had it been properly performed." He concluded distraction

osteogenesis was "not indicated."[75] Schow testified that the treatment was a "risky procedure" with a high potential for problems.

Dr. Remaklus additionally testified that Ness's surgery was "not the appropriate treatment" for R.R. He concluded that R.R.'s case should have been handled with standard orthodontic treatment. Remaklus testified that he "has not seen cuts like these [Ness's on R.R.] except in orthognathic surgery done by an oral surgeon."

Dr. Reinbold, an oral surgeon and M.D. in Alaska, testified that Ness's choice of surgery did not meet the standard of care. According to Reinbold, it was not possible to correct R.R.'s problem by "tipping teeth forward" as Ness did. Reinbold characterized Ness's surgical procedure "high risk" and one that he himself would not perform. Dr. Ness's surgery was "not the appropriate therapy to fix this guy," as R.R. needed to have his "whole jaw moved forward" to get a good result.

In contrast to the division's witnesses, Dr. McGann stated that Ness's choice of surgery on R.R. was appropriate.[76] Although Dr. Dana conceded that R.R. was a "high risk patient," Dana reported that Ness's surgery was "the best treatment alternative [other than orthognathic surgery] to achieve the best occlusion and maximum esthetics." Drs. McGann and Dana also expressed that R.R. was an appropriate patient for the surgery.

The likelihood of complications is relevant to whether R.R. was an appropriate patient. Dr. McGann stated in his July 6, 2003, report that "The incident [sic] of complications with mandibular advancement surgery is approximately 10 % of the cases, which is much less [sic] than we have experienced with corticotomy."[77] McGann may not have intended to say "less" instead of "more;" Dr. Ness submitted an ambiguous expert report on this issue. Nonetheless, McGann conceded that his knowledge of corticotomy complications was a "guesstimate" and that he was unsure if all his students reported complications to him.[78] These statements by the main proponent of the surgery at issue reflect a significant level of risk associated with Dr. Ness's procedure.

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[75] Exhibit 16.
[76] Direct exam of McGann, Exhibit O.
[77] Exhibit O, p. 700005.
[78] Dr. McGann's corticotomy study for 1993-99 which he relied on at the hearing (Exhibit AE and following) was not published, not submitted for publication, and not subjected to peer review. Ness's counsel introduced a series of slides that either embody or reflect the study, but there is little explanation of the data. The study therefore is given little evidentiary weight in this decision. Notably, however, McGann addressed seven lower labial corticotomy procedures between 1993-99 with the accompanying comments, "[o]ne had 2 procedures due to ineffective

R.R. also had pre-existing dental problems that added to the risk of this particular surgery involving cuts to the lingual and buccal aspects of the anterior mandible. Before undergoing Ness's surgery, R.R. had a history of periodontal disease[79] with bone loss and thin attached tissue in the lower incisor region. Dr. Ness stated that R.R.'s anterior labial mandibular gum was "low to begin with." Dr. Ness had placed a gingival graft in the area the year before surgery "to beef up the tissue" in anticipation of orthodontic treatment.[80] Ness told the division's investigator that R.R. "was compromised before orthodontics."[81] R.R. also had 40-50 % bone loss in the anterior mandible prior to surgery. While not a primary factor, R.R.'s pre-surgery dental condition, particularly the bone loss, diminished the likelihood of success for the surgical procedure Ness performed. According to Dr. Schow, the surgery compounded the bone loss. Bone does not grow back once it has died.

A preponderance of the evidence in the record shows that RR's surgical treatment was unnecessary in the sense that it was not a beneficial treatment choice for him. He also was not an appropriate candidate for the surgery. Dr. Ness violated AS 08.36.315(6) as alleged in Count I.

C. Surgery Was Performed in a Manner That Fell Below Minimum Standards of Performance (AS 08.36.315(6)) ***[Count II]***

The discussion will next address the manner in which Dr. Ness performed surgery on R.R. and whether Ness met minimum professional standards of dentistry.[82] Dr. Ness's position at the hearing was that he did not act outside the standard of care.

Minimum professional standards will be addressed first. Drs. Ness, McGann and Dana all testified that the surgery Ness performed on R.R. is accepted within the standard of care. In contrast, Dr. Schow, whose credentials were previously discussed, stated that Ness's surgery did not conform to minimum professional standards. Schow did not see adequate documentation in publications for the procedure.[83] He stated "the procedure kind of defies description."[84]

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mechanics following first surgery," "[o]steotomy may be a better surgical approach," and "[a]dvancement of the posterior teeth is the problem, not the anterior advancement." Exhibits BL, BP.

[79] Dr. Remaklus testified that periodontal problems did not contribute to the problems in R.R.'s case.

[80] Direct exam of Ness; Exhibit B; Exhibit 17, p. 000092.

[81] Exhibit 17, pp. 000092, 93.

[82] Allegations that the surgery was performed incompetently and that Dr. Ness lacked adequate training are addressed in the discussion for Count VI as well.

[83] Dr. Julien described studies on distraction osteogenesis from more than fifty years ago as anecdotal in nature. According to Julien, in the dental context, basic science for distraction osteogenesis started between the 1970's and 1990's.

[84] Schow testified that Dr. Ness "wasn't performing what would ordinarily be a corticotomy procedure, nor was he performing what would ordinarily be distraction osteogenesis."

The division's other witnesses generally expressed a lack of familiarity with the surgery Dr. Ness performed, whereas Drs. Ness, McGann and Dana attempted to justify the surgery as accepted and not experimental. McGann and Dana first performed similar surgery in the mid-1990's.[85] Notably, Dr. Dana denied that he had performed the same surgery that Dr. Ness performed on R.R.[86] Dana stated that he knows "little or nothing" about the specific surgical process Dr. Ness was taught involving cortical cuts for mandibular segmentation on both tongue and facial sides of the bone.[87] Yet, according to Dana, Ness performed a "surgically correct" procedure on R.R., and he did not violate a standard of care in performing surgery on R.R.

Dr. Dana's opinion on whether the execution of the surgery met the standard of care was not given much evidentiary weight. Dr. Dana never spoke with the Alaska dentists who treated R.R. (other than Ness), he never received any information from them to review, he never evaluated R.R., and he did not review any x-rays of R.R.[88]

Regardless of the dental community's degree of acceptance for this surgery, maintaining the blood supply is a crucial. According to Schow, blood supply to the tissues must be maintained.[89] Schow stated that even with the earlier corticotomies he was familiar with, "blood supply was always kept present."[90] He said that the need to maintain a blood supply "is made clear in every publication you read." Dr. McGann also agreed that basic surgical protocol requires that a dentist maintain blood supply to affected areas, and failure to do so can lead to necrosis.

Evidence in this case established that Dr. Ness's surgery was responsible for depriving R.R. of blood supply in the anterior mandible, resulting in the flap sloughing, gingival necrosis, and resultant increased bone loss with necrosis. In the words of Dr. Schow, Ness "created essentially a dead piece of bone, and the teeth within it." According to Schow, when Dr. Ness

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[85] McGann testified under cross-exam that he performed his first corticotomy in 1993, and it was an upper lingual. Dana's first was in 1996, although he has never done mandibular lingual and buccal cuts, as did Ness, in the same surgery. Cross-exam of Dana.

[86] Id.

[87] Id.

[88] Dana testified that he measured R.R.'s root exposure, an indicator of gum recession, as five millimeters. Dr. Remaklus' measurement of 10 mm is entitled to greater evidentiary weight as he personally measured R.R., whereas Dana apparently made measurements based on photos.

[89] Exhibit 16.

[90] Dr. Ness did not accomplish distraction osteogenesis. Direct exam of Schow. According to Schow, for both distraction osteogenesis and the older corticotomy procedures, "one of the prime principles is to maintain a vital soft tissue blood supply to the segment you are trying to move."

did his procedure on R.R., "all the soft tissue blood supply was removed at one time" on both sides of the segment. Schow further explained:

> In addition, he made cuts through the [cortical] bone on both the facial and tongue side so that even had there been any substantial blood supply through the bone, it wasn't available either. In essence what he created was a free segment of bone with no blood supply.

Ness told the division's investigator that even Dr. McGann expressed "that my [Ness's] flap design could have been a little different."[91] Ness repeated the admission while under cross-exam at the hearing. Ness also admitted under cross-exam that R.R.'s blood supply had been compromised.

According to Schow, problems were inevitable due to the lack of blood supply and the nature of the bone cuts, which were too wide, too deep, and too close to roots. Minimum professional standards for creating the flap required cuts that were narrower and not as deep. Schow stated that Ness had an inadequate flap design, reporting that "[a]ll osteotomy cuts were too wide and led to the root damage on teeth 21 and 28."[92]

Dr. Reinbold testified that the surgery Dr. Ness performed was probably an "incomplete osteotomy" on the labial side. He stated that osteotomy

> is a high risk procedure and it's one that I will not perform due to the fact that essentially you are de-vascularizing large segment of the bone and you are hoping you are not going to get necrosis of that bone. When I saw R.R., what he came to me with was a large segment of the anterior mandible which had necrosed and resorbed due to de-vascularization of that segment. There was exposed bone between the teeth that were black.

Dr. Ness's failure to maintain blood supply was practice that that does not conform to minimum professional standards.

The surgery also fell below minimum professional standards because it was performed in a way that failed to mobilize the bone. Evidence in the case established that distraction osteogenesis surgery by definition requires movement of bone.[93] According to Dr. Schow, it "did not appear that the section of bone was ever mobilized." If Dr. Ness wanted to term his procedure osteogenesis, "at the end of the surgery the segment of bone should be able to be mobilized and then put into a rest position for a period of several days before the bone was

[91] Exhibit 17, p. 000089.
[92] Exhibit 16.
[93] Direct exam of Schow, Direct exam of Dana.

attempted to be moved." Schow stated that in the follow up x-rays, "it's clear that the teeth were moved, but the piece of bone did not."

Dr. Ness's use of instrumentation for surgery also presents a minimum professional standards issue in this case. Dr. Schow testified that the professional standard requires a dentist to use a narrower bur instrument than Ness used for the cuts. In addition, initial bur cuts should be followed by use of a chisel. His testimony is the most persuasive on this issue. According to Schow, Dr. Ness engaged in overinstrumentation. Ness used only a bur, and the chosen instrument was too wide. Schow stated that the bur "clearly was too wide an instrument to be going between two teeth without damaging them" and Dr. Ness used "an improper technique" on R.R. and unnecessarily jeopardized the health of his teeth. Dr. Reinbold agreed that there was not enough space between R.R.'s teeth to safely perform the surgery with a bur.[94] In contrast, Dr. McGann, who teaches his surgical procedure using a bur, stated on direct exam that when a corticotomy is performed too close to the roots, "the consequence isn't terrible, but you might need a root canal."

Evidence established that Dr. Ness lacerated R.R.'s teeth roots with the bur. Dr. Schow's and Reinbold's testimony is entitled to more weight concerning the correct instrumentation for the surgery Ness performed because of their more thoughtful consideration of the need to minimize complications. Based on a preponderance of the evidence, the administrative law judge concludes that the choice of instruments fell below the minimum professional standards.

Compounding the problem of poor instrument choice was the location of the cuts. According to persuasive testimony from Dr. Schow, cuts should not go near the root apices, and Dr. Ness's horizontal cuts were too close to root apices. Given the facts that he was using the wrong instrument as well as cutting too close to the roots, the laceration of roots was outside the standard of care. Hence, Dr. Ness did not conform to minimum professional standards during R.R.'s surgery with regard to his choice of instrument as well as his use of the bur.

The number and significance of the errors Dr. Ness made in performing the surgery raise the question of whether he made an inappropriate decision to perform surgery beyond the ken of a general practitioner with his level of training. In this connection, Dr. Ness introduced as evidence a textbook by Larry Peterson, D.D.S., M.S., an accepted expert in oral and

[94] According to Dr. McGann, a bur is "like a drill" and used for cutting.

maxillofacial surgery. Excerpts from his textbook, Contemporary Oral and Maxillofacial Surgery,[95] were admitted as evidence. In the book's preface, Dr. Peterson defines the field as

> the specialty of dentistry that includes the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects, including both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. This definition is intentionally broad and all-inclusive, primarily pertaining to the specialty of oral and maxillofacial surgery. The surgery performed in the office by general practitioners is usually much less extensive than that practiced by specialists in oral and maxillofacial surgery.

The preface for the text also states "The primary purpose of *Contemporary Oral and Maxillofacial Surgery* is to present a comprehensive description of the basic oral surgery procedures that are performed in the office of the general practitioner." Dr. Peterson notes, however, that "Since a multidisciplinary approach is necessary to meet the needs of many patients, cooperation and coordination of care between the general dentist and the medical and dental specialists are essential to provide the best care."

Dr. Peterson lists several factors bearing on the scope of practice by a general practitioner performing oral and maxilliofacial surgery. They include 1) the general dentist's desire to perform surgical procedures, 2) the general dentist's "training and experience in performing complex surgical procedures," 3) the individual dentist's level of skill, and 4) "the availability of specialists" in the general dentist's vicinity. Dr. Ness performed highly complex oral surgery on R.R. in which he had had no hands-on training,[96] and he did so in a community where specialists are readily available.

The Principles of Ethics and Code of Professional Conduct that applies to Alaska dentists additionally helps to establish minimum professional standards in Alaska. The code has been adopted in Alaska by regulation.[97] Section 2 of the code addresses the principle of nonmalfeasance ("do no harm"), requiring the dentist to "refrain from harming the patient." The annotation for this provision states:

> This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to

[95] Exhibit CB.
[96] As previously addressed, he had performed it on one other Alaska patient.
[97] 12 AAC 28.905.

> refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.[98]

Both the Peterson text and the Principles of Ethics reflect a professional standard that a dentist must know his limitations and not practice dentistry outside his level of skill.

Dr. Ness lacked adequate training and experience to perform R.R.'s surgery. His training consisted mainly of lectures, and very little of the POS series he attended on corticotiomies specifically addressed the labial mandibular surgery. At the hearing, Dr. Ness maintained that he had training and experience with the surgery at issue before 2001. These representations are not credible, as Ness told the division's investigator on December 13, 2002, that he was introduced to the surgery he performed on R.R. in fall 2001,[99] and the only other time he had performed the surgery on an Alaska patient was less than two months before R.R. in 2002. Insofar as Ness's statement under cross-exam that the surgery he performed on R.R. was addressed in continuing education programs other than POS, it is given little evidentiary weight. He gave no details for this assertion and merely stated that there were other courses "to the best of my recollection." In 2003, Dr. Ness told the board in a letter that "my studies in POS introduced me to the concepts of distraction osteogenesis," and "mandibular labial rapid-advancing corticotomy" occurred in 2001.[100] Dr. Ness also testified at the hearing under direct exam that "at the time we started the appliance [R.R.'s braces placed in April 2001], the lower labial corticotomy had not been revealed to me as yet. It was about a year later." Ness further stated after R.R. had been in braces for a year, "at that time new information about the lower labial corticotomy had come up, and I had explored that."[101] Ness also testified on cross-exam that he first learned of distraction osteogenesis as a procedure applied to the lower mandible in fall 2001. Some of Dr. Ness's witnesses suggested that Ness received mid-1990's training for the surgery he performed on R.R. The contention is not credible in light of Ness's own statements.

With regard to Dr. Ness's pre-licensure training, Ness testified during direct exam that orthodontics is "admittedly one of the least in-depth areas we are taught." Dr. Ness attended POS seminars, in his words, "to learn orthodontia."[102] In Dr. McGann's view, the lower labial

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[98] The regulation addresses revisions until April 2002. The division's exhibit 18 is a 2005 version. Upon comparison, the relevant language for both versions is identical.
[99] Exhibit 17, p. 000063.
[100] Exhibit 1.
[101] Direct exam of Ness.
[102] Ness testified "any general dentist that wants to apply himself can learn how to do orthodontics to whatever level they want to take it," and "the philosophy of POS is to make the system, make the orthodontics available for even the worst student in the class." Direct exam of Ness.

corticotomy procedure he taught Dr. Ness was "surgically assisted orthodontics."[103] McGann noted on cross-exam, however, that "our focus is not on surgery, we would rely on the surgical skills that had already been taught in dental school." Dr. Ness testified under cross-exam that he never had hands-on training for the procedure while in McGann's program. He also told the division's investigator "we don't have active patient treatment" at POS.[104] Dr. Dana testified on cross that POS attendees receive no "hands-on" training and there is "no clinical instruction." While recognizing that his POS seminars did not teach surgery, however, Dr. McGann stated that "for the surgery of the lower labial corticotomy, any dentist that graduated from dental school, any dentist, even the bottom of the class that got through, is capable of doing that. It is not a major procedure."

Ness told the board in his 2003 letter that he was not trained in potential complications that could happen from this type of surgery on the mandible, and "I lack the global insight into the potential complications that could arise from this surgery that an oral surgeon would have. I understand now that they would be the best to perform this procedure."[105] During Dr. Ness's cross-exam, in response to the question "So, you think the training that you received at POS gave you enough training to be able to perform a corticotomy on R.R.?," Dr. Ness stated "For me to personally perform it . . . no." Yet he also stated, during the same cross-exam when asked if he was qualified to perform the surgery, "I felt that I was, at that time, yes. Otherwise, I wouldn't have done it. I would have referred it out."

The more persuasive evidence was that Ness should not have attempted the surgery with his level of skill, experience and training. When asked if a general dentist would have adequate training to perform the surgical procedure on R.R., based on lecture attendance without clinical training, Dr. Reinbold responded "absolutely not." When the question was put to Dr. Schow as to whether Ness had adequate training and experience, he responded:

> Clearly – no. Procedures of this kind should be performed by a fully trained surgeon with experience in this type of surgery, knowledge of the physiology of bone and bone healing and expertise in recognizing and dealing with complications if they occur. . . . Experience in continuing education courses by an untrained surgeon is not sufficient to warrant his performance of such procedures.[106]

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[103] Ness also referred to the procedure he performed as "surgically assisted orthodontics."
[104] Exhibit 17, p. 000088.
[105] Exhibit 1.
[106] Exhibit 16.

Dr. Schow elaborated that "Dr. Ness clearly does not understand the concept of distraction osteogenesis and does not appreciate the need of keeping a blood supply to the tissues. His treatment selection was poor and his technique even worse."[107] Dr. Ness's lack of knowledge about the procedure and appreciation for its complexity was revealed by his statement "to me it's a degree of difficulty of some periodontal surgery or removing an impacted wisdom tooth."[108] According to Dr. Schow, during Ness's attempted distraction osteogenesis "[t]he appliance did not move the bone – it only moved the teeth out of the sockets." Schow's report concludes "it is clear to me that Dr. Ness is performing procedures beyond his training, experience and expertise." According to Drs. Schow, Reinbold and Michael (a general dentist in Alaska), the standard of care requires hands-on training experience to perform the surgery Dr. Ness attempted on R.R. Ness had no hands-on clinical experience in learning this complex procedure prior to performing it on an Alaska patient just before R.R.'s surgery.

The evidence from Dr. Schow and Alaska dentists in this case overwhelmingly refute Dr. Ness's comparison of the complexity of the subject surgery to a wisdom tooth extraction and Dr. McGann's representation that it is not a major procedure. The surgery Ness performed on R.R., particularly given R.R.'s condition, was a complex, difficult, and high risk procedure. Applying the Peterson text, it was a complex oral surgery procedure.

Although he was less frank during the hearing, Dr. Ness admitted in his June 5, 2003, letter to the board "I take full responsibility for not realizing that my training was not sufficient to perform such a complicated procedure." Dr. Peterson's text states "Even with a high interest level and with extensive training, a dentist with little or no skill in the surgical arena should probably not perform complex surgical procedures."[109] In Peterson's text, flap design is addressed in the chapter entitled "Principles of Complicated Exodontia."[110] Dr. Reinbold testified that the surgery Dr. Ness performed on R.R. was complex insofar as it de-vascularized a segment of bone.

The administrative law judge concludes, based on a preponderance of the evidence, that Dr. Ness did not receive adequate training and experience during his dental school studies, the POS lecture series, and practice to obtain sufficient expertise for the "surgically assisted

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[107] Id.
[108] Exhibit 17.
[109] Exhibit O, p. xiii (emphasis added).
[110] Id., pp. 156-57 (emphasis added). "Distraction osteogenesis with surgically assisted palatal expansion" is the last page of Exhibit O from the Peterson text. Ness performed a far less common and less accepted surgery on R.R.

orthodontia" he performed on R.R. This lack of expertise was the likely cause of the numerous errors made in the execution of the surgery.

Based on the preceding considerations and the evidence in this case, Ness's surgery on R.R. did not conform to minimum professional standards in violation of AS 08.36.315(6) as alleged in Count II.

D. Aftercare Fell Below Minimum Standards of Performance Due to Failure to Timely Refer the Patient (AS 08.36.315(6)) ***[Count III]***

Count III alleges that Dr. Ness's post-surgical care was performed in a manner that conform to minimum professional standards because Ness failed to timely refer R.R. to a specialist. As with discussion of Counts I and II, this allegation overlaps with Count VI, which alleges unethical conduct based on reasons that include Dr. Ness's failure to timely refer R.R. to an appropriate specialist when the need arose. The referral issue will be addressed in this section of the decision and reference will be made to this discussion, as necessary, in the Count VI analysis which follows in the next section.

Minimum professional standards for referral to a specialist derive from the following sources at the hearing. To begin, by virtue of the board adopting the ADA's Principles of Ethics and Code of Professional Conduct,

> Dentists shall be obliged to seek consultation, if possible, whenever the welfare of the patients will be safeguarded or advanced by utilizing those who have special skills, knowledge and experience.[111]

In this case, unlike the possible scenario addressed by Dr. Peterson in his textbook,[112] consultation with specialists was readily available in Anchorage. Under the nonmalfeasance principle of the ethics code, an Alaska dentist has a duty to protect the patient. As an adjunct to this principle to "do no harm," a dentist has primary obligations to know his own limitations, as well as "when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate."[113]

Dr. Peterson's text, introduced into evidence by Ness, does not set the minimum professional standard for referral in Alaska, but it nonetheless provides a useful reference. Peterson states "The general practitioner has the legal right to perform any oral and maxillofacial surgery. Therefore each dentist must decide which surgical procedure to perform and which

[111] Exhibit 18, p. 4 (2.B. Consultation and Referral).
[112] Exhibit CB, p. xiii.
[113] Exhibit 18, p. 4.

should be referred to a specialist, keeping in mind the best interests of the patient."[114] What Peterson refers to as legal authority of a dentist to perform any surgery is limited by the Principles of Ethics and Code of Professional Conduct provisions addressing competence[115] and referral.[116] Moreover, keeping the patient's best interests in mind operates as a constraint on unbridled practice of specialized dentistry by a general dentist.

Dr. Ness was aware healing problems existed on June 17, 2002, when he "observed that the labial flap had dehisced, exposing the tooth roots and alveolar process.[117] On June 19, 2002, Ness entered the chart entry "May need hyperbaric O_2 in healing." Early in R.R.'s post-operative treatment, perhaps as early as June 24, 2002, Dr. Ness realized there was a possibility of R.R. getting an infection in the exposed bone.[118] He therefore prescribed antibiotics for R.R.[119] Dr. Ness's June 24, 2002, chart note states the important concern, "(blood supply?)." [sic] Dr. Ness told the division's investigator during the 2003 interview that when he observed R.R.'s exposed bone after expansion had started he was concerned that the blood supply had been compromised.[120] With bone dying, R.R.'s situation only worsened through June 27, 2002, when Ness removed the expansion appliance at R.R.'s insistence. Even before the expansion appliance was removed from R.R.'s mouth on June 27, 2002, Ness debrided dead bone in the area while at the same time assuring R.R. that nothing was amiss. On July 1, 2002, more than three weeks before Dr. Matthews was consulted, Ness admitted in a To Whom it May Concern letter: "At this time, the block segment of bone is in jeopardy of becoming infected, potentially resulting in loss of teeth and/or bone, a serious and debilitating complication."[121] Yet, until Ness sought consultation with Dr. Matthews seven weeks after surgery, he had told R.R. there was "nothing to be gained" by referral."[122]

Dr. Ness testified under cross-exam that during the first month of healing after surgery, "[a]n endodontist wouldn't have helped me. An oral surgeon or a periodontist, really, it

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[114] Exhibit CB, p. xiii.
[115] Exhibit 18, p. 4 (Nonmalfeasance).
[116] Id. (Referral).
[117] Exhibit 4, p. 100019.
[118] Dr. Ness stated: "I mean I, at his point, I didn't kind of know how the course would go here, cause this was so different than all the other cases and situations that I'd seen. So I saw him probably every couple days. . . . I would have him in and I would find dead bone in the area that was, that was exposed to the air and I would, I would try to debride and clean it out . . .." Exhibit 17, pp. 000075-76.
[119] Id. p. 075; Exhibit 4, p. 100005.
[120] Exhibit 17, p. 000075.
[121] Exhibit 4, p. 100019.
[122] Cross-exam of Ness.

wouldn't have helped the outcome at that point of time." He had held a different view in his 2003 letter to the board, where he stated, "In retrospect, I believe I should have contacted a periodontist and oral surgeon immediately to assist in addressing the complications." At the hearing, he testified equivocally in response to the question whether he still believed he "should have contacted a periodontist and oral surgeon immediately to assist in addressing the complications:"

> No. As a practical matter and as a patient management or, in retrospect, mostly because, you know, I understand [R.R.'s] concerns, and while it wouldn't have changed the healing outcome it may have helped him emotionally and might have been a wise thing to do, thinking about it now. So I would think that I disagree with that statement.

R.R.'s facts present a classic case for the need to refer to a specialist. Timing was crucial for R.R. R.R. had major complications for which his general dentist was insufficiently trained, and R.R. repeatedly requested referral. Unfortunately, Ness refused. Dr. Ness testified "I wanted to finish the case." Some of the delay in making a referral also appears to have resulted from ignorance—ignorance born of lack of training and of failure to investigate. His delayed referral of R.R. was not in the best interest of his patient.

Dr. Ness stated that he did not see any complications at the end of the surgery.[123] X-rays would have revealed the lacerated roots. Ness first realized "I had cut some roots during the vertical cuts" after he took x-rays. According to his chart notes for R.R., the post-op x-rays were taken July 29, 2002, seven weeks after the surgery and long after serious complications developed. Ness also testified that he did not realize there was root damage until late August.[124] Ness's failure to timely ascertain the existence of R.R.'s lacerated roots did not conform to the minimum professional standard.

Throughout June and nearly all of July, R.R. repeatedly requested referral and Ness declined. In disregarding R.R.'s requests for referral, Ness was not "keeping in mind the best interests of the patient" as Dr. Peterson advises in his textbook. As an ethical matter, he was not giving adequate attention to his ethical duties to refer to a specialist and to refrain from harming his patient.

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[123] Exhibit 17, p. 073. Dr. Ness stated in his interview with the division's investigator that he "gouged" the teeth where he made the vertical cuts. Id. pp. 075, 079. However, he only acknowledged that he learned of the damaged roots after the hyperbaric treatment ended.

[124] Exhibit 4, p. 100004. Late in his direct exam, Dr. Ness said that he learned of the damaged roots when viewing x-rays taken by Dr. Remaklus. That meeting occurred on August 28, 2002. Exhibit 10. Ness's sworn direct exam testimony on this important fact was credible.

Dr. Schow testified that Dr. Ness failed to adequately recognize R.R.'s post-surgery complications, and termed the complications "not reversible."[125] According to Schow, referral "should have happened as early the complication was recognized." Ness's referral to hyperbaric treatment was about three weeks after surgery. At this point, evidence of the complication was clearly evident. "Recognizing the complication was late, and dealing with it was even later."[126]

Dr. Frederick Reinbold is a board certified oral surgeon, with four years of training in residency as a surgeon after dental school. He also is a medical doctor. Dr. Reinbold evaluated and treated R.R. as part of the team after R.R. was referred by Dr. Remaklus. According to Reinbold, R.R. should have seen a referral specialist even before Ness performed the surgery. In addition, Dr. Ness failed to conform to minimum professional standards by not referring R.R. to a specialist after surgery when necrosis first appeared and later when teeth mobility in the segment became apparent.[127]

Dr. Julien testified that referral should have occurred as soon as it was noticed the bone had receded.

In contrast to the division's witnesses, Dr. McGann testified that Dr. Ness's post-operative care for R.R. was "exceptional and above and beyond what would be expected." His report states: "The surgical complication was handled with diligence and care by Dr. Ness."[128] McGann testified at the close of his testimony, "Every possible thing [Ness] could think of was being done, including consulting with me, hyperbaric oxygen, removing appliance, let's stabilize the teeth. He did everything and more." McGann's position implicitly supports the proposition that the standard of care does not require referral to a specialist when faced with complications such as R.R. had. This testimony was not credible in the face of the convincing explanations of Schow, Reinbold, and others of the need for earlier referral.

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[125] Dr. Schow indicated that complications occurred during the surgery (cuts too wide, bur too deep, root damage, cutting off blood supply). Schow stated that this "underscores the fact that Dr. Ness was not really familiar with what he was doing." "It was more an error in [Ness's] judgment than anything else." Dr. Schow concluded his testimony by stating Dr. Ness "went beyond his expertise" and "there's a confidence level that's not justified by the expertise."

[126] Schow testimony. Dr. Schow also said: "The complications actually began during the surgical procedure with over-instrumentation, over-reflection of the soft tissues" and "Clearly, when complications were recognized, Dr. Ness didn't seem to have the ability to deal with them or the knowledge to either recognize them or deal with them until it was too late." Referral to hyperbaric treatment did not constitute referral to a specialist in dentistry.

[127] "[T]rying to treat a complication of this magnitude should have been something that was referred out for specialty care." Direct exam of Reinbold.

[128] Exhibit O.

Dr. Ness's referral to Dr. Matthews was too late whether one deems the time at which referral should have occurred to be when the flap sloughed, when Ness first noticed the exposed bone, when necrosis appeared, when advanced tooth mobility was apparent, or when hyperbaric treatment took place.[129] The regulation at 12 AAC 28.905, which incorporates by reference the ADA's ethical principle of nonmalfeasance ("do no harm"), addresses the duty to refer in order to protect a patient from harm conditioned on "knowing one's own limitations and when to refer to a specialist." While not a binding precedent in Ness's case, a published medical board decision provides some guidance with regard to the standard of care for referral. In Storrs v. State Medical Board, an inordinate delay by a physician in treating post-operative complication and the physician's failure to call in a consultant was a "significant deviation from accepted practice."[130]

Dr. Ness's referral was too late. He did not refer to a specialist until July 25, 2002, when he sought the opinion of Dr. Matthews. Ness's delay in referring R.R. to Dr. Matthews was neither compliant with knowing "when to refer to a specialist" as required by 12 AAC 28.905(b)[Section 2] / Nonmalfeasance Principle], nor "keeping in mind the best interests of the patient" per Dr. Peterson.

Like the poor execution of the surgery discussed in the preceding section, the poor aftercare was likely a result of inadequate training and experience to attempt the surgery in the first place. Testimony of Dr. Schow, the Peterson text, and the Principles of Ethics establish that a dentist must be adequately trained to deal with complications from surgery they perform. Putting aside the possibility of unforeseen complications, for which referral may be appropriate, there must at a minimum be adequate training for the reasonably foreseeable complications.

Dr. Ness did not receive adequate training for dealing with complications. He told the board in his June 5, 2003, letter that "We never discussed [at POS courses] the potential complications that could happen from this type of surgery on the mandible."[131] At the hearing,

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[129] Dr. Matthews' evaluation should be given limited weight as evidence in some respects. He saw R.R. less than a week after R.R. had seen Remaklus on his own. Remaklus viewed x-rays, noted the lacerated roots, and saw the need for extractions. Matthews did not take x-rays for his evaluation of R.R. His referral card states in bold PLEASE SEND RADIOGRAPHS. Ness took post-operative x-rays of R.R. on July 29, 2002, the same date as the referral. Matthews does not mention x-rays or the lacerated roots. He nonetheless recognized in his letter that tissue and bone were dying, and that "mobility cannot be measured" due to the splint. Exhibit 4, p. 100015. Matthews did not provide sworn testimony in the case.

[130] Storrs, 664 P.2d 547, 556 (Alaska 1983).

[131] Exhibit 1. When Ness was asked at the hearing whether he still maintained the position from his letter to the board that POS did not discuss complications for the surgery, Ness responded "Not completely, no." His carefully considered letter to the Board of Dental Examiners, however, is the more persuasive evidence on this issue.

Ness testified that R.R.'s healing complications from the surgery he performed was "new territory for me." Dr. McGann stated in his report for this case that "At the advanced seminar that Dr. Ness attended, there was discussion of complications, and the history of corticotomy, but I believe this to be after the incident of [Ness's] surgical error."[132] Dr. Ness was not trained in recognizing complications from the surgery. He was not acting in conformance with minimum professional standards in performing surgery on R.R. without adequate training in dealing with complications.

For the preceding reasons and based on a preponderance of the evidence, Dr. Ness failed to timely refer R.R. to a specialist. Consequently, he did not perform to minimum professional standards. He violated AS 08.36.315(6) as alleged in Count III.

E. Violation of Ethical Standards (AS 08.36.315(7) and 12 AAC 28.905) ***[Count VI]***

Count VI alleges unethical conduct by Dr. Ness based on AS 08.36.315(7) and 12 AAC 28.905. The cited statute provides that the board may discipline a dentist who "failed to comply with a regulation adopted under his chapter." The regulation states

> **12 AAC 28.905. Ethical standards.**
>
> *** * ***
>
> (b) The American Dental Association's *Principles of Ethics and Code of Professional Conduct,* with official advisory opinions revised to April 2002, is adopted by reference as the ethical standards for dentists, and applies to all dentists in the state.

Adoption of the ADA's ethical standards reflects "the board's regulatory goal of maintaining high ethical standards for the profession."[133] Section 2 of the *Principles of Ethics and Code of Professional Conduct* addresses **Principle: Nonmalfeasance ("do no harm")**. The principle states "The dentist has a duty to refrain from harming the patient." As noted previously, the annotation for this provision makes it clear that it encompasses "knowing one's own limitations and when to refer to a specialist or other professional."

The division argues that Dr. Ness's conduct involving R.R.'s surgery and its complications was unethical under the nonmalfeasance principle because "the surgery was unnecessary, the surgery was performed incompetently, Ness failed to recognize he was not

[132] (emphasis added) Exhibit O, p. 700004. McGann also testified on cross-exam that Ness initially brought R.R.'s complications to McGann's personal attention, not to the seminar group.
[133] Wendte v. State of Alaska, 70 P.3d 1089, 1094 (Alaska 2003).

qualified to perform the surgery, and he failed to timely refer the patient to appropriate specialists when the need arose." Dr. Ness contested each of these allegations at the hearing.

As previously addressed in the discussion for Count I, the surgery was unnecessary. Dr. Schow's opinions were given great weight in this determination. The discussion for Count II addresses whether the surgery was performed incompetently. Dr. Ness did not competently perform the surgery, as the procedure did not conform to minimum professional standards. Ness used the wrong instrumentation, and he used the wrong technique. He lacerated teeth roots and his flap design was inadequate. He not only failed to recognize that he was not qualified to perform the surgery, he misled R.R. about the surgery and his training in order to induce consent.[134] Finally, the discussion for Count III addresses failure to timely refer the patient to a specialist. Dr. Ness's primary obligations under the ethical principle to "do no harm" to his patient included "knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate." Dr. Ness did not timely refer R.R. to an appropriate specialist when the need arose. His referral to Dr. Matthews was too late, and permanent damage from much of R.R.'s complications, particularly bone loss, were "not reversible" at that point.

The preponderance of the evidence, including the matters highlighted in the discussion of Counts I, II and III, establish that Dr. Ness engaged in unethical conduct violating the nonmalfeasance principle. He breached his ethical duty to protect R.R. from harm. Ness therefore violated AS 08.36.315(7) and 12 AAC 28.905(b) as alleged in Count VI. The infractions are considered one violation, as AS 08.36.315(7) derives from conduct that violates 12 AAC 28.905.

F. Sanctions

AS 08.01.075 enumerates board options for disciplining a licensee. They include permanent revocation, suspension, censure, issuance of a letter of reprimand, probation, civil fine,[135] continuing professional education, and probationary status. Under the statute, disciplinary options may be imposed singly or in combination. The board also has discretion to impose no sanctions at all. The discretion granted to impose a wide variety of sanctions reflects

[134] This lack of candor is troubling in light of the ethical duty of veracity. See AS 08.36.315(7); 12 AAC 28.905(b); Exhibit 18, p. 8 (veracity).

[135] Under AS 08.36.317, the board's civil fine authority was increased in 2001 to a maximum of $25,000 for each violation.

broad deference to the board's expertise in carrying out its statutorily based authority over the practice of dentistry in Alaska. With regard to the suspension sanction, there is no magic formula for determining the appropriate length.

1. Prior Decisions

Although discipline may be tailored to the particular circumstances of each case, AS 08.01.075(f) nonetheless requires the board to be consistent in applying disciplinary sanctions. Under this provision, the board may significantly depart from prior decisions involving similar facts only if the reasons are explained. No prior decisions by this board deal with facts that closely parallel Dr. Ness's case, but several are worth reviewing either because they were pointed out by a party or because they have at least some elements in common with this case. Decisions regarding dentist discipline in other jurisdictions, though sometimes of interest when brought to the board's attention, are not binding on Alaska's board, and none has been offered here.[136] Professional licensing is uniquely a state prerogative, and the Alaska Legislature has delegated disciplinary matters to the Board of Dental Examiners.

One court decision in Alaska addresses discipline of a dentist. In re Smith arose from the death of two patients under anesthesia administered by a dentist. Smith pleaded nolo contendre to two misdemeanor counts of assault and battery. A subsequent license revocation proceeding by the division of occupational licensing resulted in revocation of his license.[137] The severity of the misconduct and the harm puts the case in a different class from Dr. Ness's.

In arguing the sanctions issue in this case, Dr. Ness cited two recent unpublished memoranda of agreement (MOAs) from Alaska dentist disciplinary cases, In re O'Donoghue, and In re Kennedy.[138] Reflecting the compromise nature of the documents, neither of the MOAs contains an admission of facts by the dentist. The O'Donoghue MOA states, "The following allegations have been made and do not represent a factual admission by O'Donoghue." The Kennedy MOA states, "Kennedy admits to the following facts (or neither admits nor denies the following allegations)." There was no testimony subject to cross-examination, and no evidentiary hearing took place. However, the division did not object to official notice of the

[136] Dr. Ness urged that dentist disciplinary cases in Rhode Island and West Virginia should be used to guide discipline in this case, but he did not submit copies of cases that the board could review.
[137] State of Alaska v. Smith, 720 P.2d 40, 41 (Alaska 1986).
[138] Unsigned Memoranda of Agreement were admitted as Exhibits AB and AC. They were eventually signed and adopted as board orders in 2004.

recited facts, and therefore they should be accepted for purposes of the comparison to be conducted in this decision.

The facts recited in the O'Donoghue decision, while not admitted, indicate that the licensee misrepresented the periodontal health of a patient in a letter to the patient's employer, a maritime career-training program. The dentist stated that his patient's "periodontal health is very good with no signs or symptoms of periodontal disease." In contrast, the same day as the letter, the dentist had treated the patient and reported that "treatment of ten teeth (seven carious teeth and three impacted wisdom teeth) could be delayed, with a minimal risk of pain or infection, for up to twelve months." A second evaluation the following month by another dentist found generalized gingivitis. The board and the dentist agreed to one year of probation, fifteen hours of continuing education, a $2,500 fine, a reprimand, and random audits.

The facts recited in the Kennedy decision, while not admitted, indicate that upon examining a patient, the licensee failed to identify occlusal prematurities of new restorations, failed to completely diagnose [the patient's] occlusal problem before equilibrating the patient's dentition, failed to properly inform his patient of what and why he was doing the equilibration, and failed to diagnose the endodontics problem with tooth # 11. The dentist also spoke on the phone with the patient about her acute infection over tooth # 11 and stated that he would call her right back. However, the dentist did not timely return her call. The agreed sanction was six months of probation and a reprimand.

Neither O'Donoghue nor Kennedy involved a complicated surgery, beyond the dentist's training, with both the surgery and the aftercare performed below minimum professional standards and with serious complications, as in Ness's case. O'Donoghue and Kennedy show the sort of discipline that historically has been applied in much less serious cases.

In addition to the two MOAs, both parties in Dr. Ness's case alluded to a failed settlement by which the parties attempted to resolve this disciplinary action. Dr. Ness referred to it during his opening statement and during testimony in the case. Investigator Younkins testified, without objection, that the division[139] in this case sought to reach an agreement with Dr. Ness

[139] Ness's counsel asked investigator Younkins, "[t]he division's position in this case . . . came from Dr. Warren, and you're in contact with Dr. Warren is that correct?" Younkins answered "correct." Cross-exam of Younkins. It may be that the board, or a board member, had a role in authorizing or encouraging the division to make the proposal. This role may be appropriate or even desirable. However, if one or more members of the board has in fact been drawn into settlement negotiations with Ness, the board should seek a legal opinion regarding whether, and under what circumstances, that member can participate in the future as an arbiter in the case.

imposing a fine and a suspension.[140] No settlement occurred.

Resolving a disciplinary case by MOA involves compromise by both parties taking into consideration such things as uncertainty about whether the allegations will be fully proven and concern about the drain upon resources that full litigation would entail. In addition, it is not uncommon for a board to refuse to accept a proposed memorandum of agreement jointly brought forward by its staff and a licensee.[141] In attempting to settle a case, the parties do not yet have the benefit of all the evidence, including witnesses' cross-examination. For these reasons, a prior, unaccepted settlement proposal has no precedential value and should not be regarded as a ceiling or a floor to later resolution after a hearing.

Prior decisions by the board after a full hearing are the most helpful benchmarks regarding appropriate sanctions. There are three decisions of this board that potentially provide some guidance.

The first of these is In re Dale A. Houseman, No. 1200-89-00011, in which the board adopted a recommended decision on June 14, 1990.[142] Dr. Houseman treated one patient in a manner that fell below minimum professional standards. In brief, the misconduct involved poor restorative treatment on two deciduous teeth of a "seriously agitated" juvenile patient. The poor quality repair was found to be understandable given the patient's agitation, but Dr. Houseman's failed to ensure follow up care to ensure that the deficiency was corrected. This was found to fall below the minimum standards of the profession. The affected teeth survived, however, and adult teeth later erupted normally.

Dr. Houseman's treatment error was much less profound than the multiple errors of Dr. Ness. Dr. Houseman did not induce a patient to let him attempt a complex procedure for which he was unqualified, for example. He neglected to follow up on a temporary repair to two baby teeth. The consequences of the error to the patient were trivial when compared to the consequences to R.R. Like Dr. Ness, Dr. Houseman was a popular dentist with no prior discipline before the board.

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[140] In addition to Dr. Ness having waived objection to this settlement overture being part of evidence, under AS 44.62.460(d) Evidence Rule 408 (Compromise and Offers to Compromise) does not apply.

[141] Settlement of a disciplinary matter lies within the discretionary authority of an agency. In deciding whether to pursue formal proceedings, "Questions of law and fact, of policy, of practicality, and of the allocation of an agency's resources all come into play in making such a decision." Vick v. Board of Electrical Examiners, 626 P.2d 90, 93 (Alaska 1981). It is not uncommon for occupational licensing boards and commissions to enter a Memorandum of Agreement in a compromise settlement of a disciplinary case.

[142] This was the first Houseman decision. Subsequently, the board took much stronger action following probation violations and other misconduct by Houseman. The subsequent actions are difficult to compare to this case.

The board's response was to impose the following discipline:

-- a public reprimand

-- six months of probation

-- one week of relevant continuing education

-- ten-day suspension of Dr. Houseman's license.

The imposition of a suspension in a case involving a single patient, and where the misconduct had minimal consequences to the patient, is noteworthy. Part of the reasoning for this relatively firm sanction was the determination that "Dr. Houseman's attitude and demeanor indicated he does not appreciate the seriousness of this case." The board concluded that the suspension was needed to deter future misconduct by Dr. Houseman.

A second potentially relevant prior case is In re Patrick A. Robinson, D.D.S., No. 1200-95-013, adopted by this board on September 13, 1996. Robinson prescribed drugs that were not dentally necessary on a number of occasions, conduct that might loosely be analogized to performing surgery that was not dentally necessary, one of the errors committed by Dr. Ness. Like Dr. Ness in his attempts to pass blame to the team who decided on extractions in the summer of 2002, Dr. Robinson was found to have tried to blame others for his own mistakes. In Robinson, the board revoked the dentist's license and fined him $5,000.00. However, there were considerably more severe aggravating circumstances in Dr. Robinson's case than in this case, including the fact that his misconduct involving prescription drugs was potentially criminal. It may also be important that Dr. Robinson had only just moved to Alaska, and had immediately embarked upon systematic improprieties as soon as he arrived. He had no history of acceptable practice here to counterbalance his misconduct. Though not wholly without parallels to this case, Robinson was a different and more severe case meriting a more severe sanction.

A third benchmark is In re Harry W. Greenough, DDS, No 1200-96-5, decided by this board in 1998. Prior to coming before the board that year, Dr. Greenough had been disciplined twice before for writing prescriptions that were not dentally necessary in connection with a number of patients. The discipline for the first violation had been probation only; for the second, it had included a 60-day suspension, two $5000 fines, additional probation, and surrender of prescription privileges.[143] Dr. Greenough was still on probation from the second proceeding when he came before the board the third time.

[143] The second round of discipline was an MOA, but in contrast to Kennedy and O'Donoghue, the facts were admitted.

Dr. Greenough's third set of violations involved three instances of misconduct:

- obtaining a prescription despite his loss of prescription privileges by misrepresenting his identity; in a related action, he destroyed physical evidence of his misconduct
- conviction for felony theft in connection with a Medicaid and insurance fraud scheme
- conviction for felony falsification of business records in connection with the same scheme.

Before this board, Dr. Greenough stipulated that his convictions reflected "multiple instances of intentionally deceptive and fraudulent behavior.

The board's response was to impose the following discipline:

-- two year suspension of Dr. Greenough's licence

-- continuation of the prohibition on writing prescriptions

-- five years of probation.

The Greenough case, like the Robinson case, is clearly one that called for more discipline than the Ness matter. Dr. Ness's case lacks any parallel to the criminal misconduct that Dr. Greenough had engaged in. Furthermore, Dr. Greenough had prior discipline (including imposition of a suspension), and he reoffended while still on probation.

2. Circumstances of this case

A number of mitigating factors apply in Dr. Ness's case. He has not previously been disciplined by the board or subject to a disciplinary complaint. In strong contrast to Dr. Robinson, he has been practicing successfully in Alaska for seventeen years. The conduct upon which Ness's discipline is based stems from a single surgical procedure on one patient, although his case encompasses not only the procedure itself but numerous pre- and post-surgical treatment decisions. The patient did not die, as in the Smith case. No criminal activity is at issue in this case, in contrast to the Greenough and Robinson matters.

To address Dr. Ness's competency and possibly mitigate sanctions, witnesses at the hearing testifying for Ness generally expressed their opinions that he is a competent dentist and a great boss. Employees and former employees of Dr. Ness testified. In general, they gave unqualifiedly positive reports about his dentistry skills. Most current employees had a

substantial personal interest factor, pecuniary in nature,[144] that was considered in weighing the evidence they presented.

Dr. Ness elicited the opinion from Dr. Schow at the end of Schow's cross-examination that Ness "has behaved responsibly" in assuming responsibility for R.R.'s problems resulting from the surgery. However, Dr. Schow likely was not aware of Ness's changed posture at the hearing to deny his errors or shift responsibility to others.

In this case, aggravating factors exist for the board to consider in choosing disciplinary sanctions. Although Dr. Ness previously took full responsibility for his actions in his communications with the board and during the investigation in 2003, he recanted much of this at the hearing. During the hearing, Ness frequently took an opposite position from his prior admissions to the board about his lack of adequate training, his failure to appropriately deal with his patient's complications, and the success of the surgery. The numerous inconsistencies between Dr. Ness's testimony and his prior statements may be considered in choosing the sanctions.

In addition to contradictions in his testimony, Dr. Ness appeared at times deliberately to seek to make the issues more obscure. For example, Ness criticized Dr. Julien for referring to the surgery as "distraction osteogenesis." Yet, Ness's June 5, 2003, letter to the board refers to his "distraction osteogenesis surgery." Moreover, Ness's expert and mentor, Dr. McGann, spent much time testifying about distraction osteogenesis, and he referenced the Peterson text to describe the procedure. Dr. Ness also criticized Dr. Remaklus for referring to the procedure as segmental osteotomy. Yet, Ness referred to the procedure as "mandibular segmental osteotomy" in his July 1, 2002, To Whom It May Concern letter, a copy of which was provided to Remaklus.[145] Dr. Schow observed that Dr. Ness changed terminology for describing the surgical procedure he performed on R.R., initially calling it a corticotomy,[146] and then in documentation

[144] Dr. Ness's staff who testified as to his professional competence have an obvious interest in continuing employment. There also was evidence of interest based on the fact that Dr. Ness gave his employees lavish gifts, including trips, shopping sprees, and for one, a gold bracelet with diamonds.

[145] In closing argument, Ness argued that "osteotomies should not be done by general dentists and should be done by oral surgeons in a hospital."

[146] The general term corticotomy is an "old procedure" according to Dr. Schow, and it is addressed in literature in the 1950's and 1960's. It was a "stage procedure" where cuts were made on one side (facial or tongue), healing allowed to take place for 4-5 weeks, and then cuts were made on the opposite side of the bone. "In that fashion, a blood supply was always kept present to the segment that was being mobilized." Ness cut both sides on R.R. the same day. In contrast to corticotomy, osteotomy involves cutting both the cortical and medullary bone. ("going all the way through") Direct exam of McGann. Whether or not Dr. Ness performed an osteotomy, he described the surgical procedure to R.R. using that term (exhibit 5). Even in To Whom it May Concern letters on July 1 and 3,

after 2003 using the term osteogenesis.[147] At the end of the hearing, Dr. Ness just generically referenced the procedure as "surgical orthodontic therapy," as Dr. Matthews did in his August 9, 2002 letter to Ness.

In Dr. Ness's June 5, 2003, letter to the board sent long after the disciplinary investigation commenced, he accepted full personal responsibility and represented that he would no longer perform the surgery.[148] In contrast, by the end of this hearing, he recanted his acknowledgment of fault and personal responsibility, relying on testimony of Drs. McGann and Dana who support the surgery as the professional standard for Alaska. Ness no longer recognizes that a higher level of practice is required.

Notably, Dr. Ness would not agree at the hearing to cease performing the surgery. He testified when addressing the letter to the board by which he previously agreed not perform the surgery anymore: "At the time, during that time, I would have agreed with that. I have a different opinion now." He further stated that a general dentist who "has a comfort zone of doing cortical surgery in that area, I think should be allowed and be able to do it." Ness also equivocally testified on cross-exam at the hearing that in the future with a case like R.R.'s (lower labial corticotomy), he would "most likely refer it out." The formal position his defense took in the case is that "Dr. Ness is operating at a much higher level of competence" and that "He [Ness] is the one establishing the standard of care." Without a clear correction from the board, therefore, he may feel free to conduct the surgery again, without referral to a specialist.

Dr. Ness argued that he should not be punished by the board and that a suspension in this case is disproportionate to what he characterizes as complications arising from a single procedure, to be viewed in the context of the thousands of patients he has served.[149] He expressed concern that a suspension will injure his reputation and additionally could have a much greater financial effect on his business than would a fine. To this end, he volunteered that his malpractice insurance premiums have risen from $3,000 to $36,000 annually, with coverage available only through secondary carriers, due in part to his surgical error and also to the fact that

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2002, regarding hyperbaric treatment, Ness referred the surgical procedure he performed the prior month as an osteotomy. (Exhibit 4, pp. 100019-20).

[147] The terms are not interchangeable according to Schow. With the newer technique in current dental practice, distraction osteogenesis, "soft tissue pedicles or soft tissue blood supply to the segments are always maintained. That wasn't the case with this patient [R.R.]"

[148] The letter is attached to this decision.

[149] "While I feel I did make an error in this one microscopic portion of my practice, my side or myself and the department [sic] of occ licensing could never come to an agreement at what an appropriate discipline would be." Direct exam of Ness.

his discipline matter is unresolved. He testified about the expensive legal defense costs he has incurred. He also expressed how his inability to practice would inconvenience his patients.

The argument that the multiple violations in this case, because they arise from an isolated maltreatment of a single patient, cannot be sanctioned by a suspension is a legally erroneous one. The legislature has not so limited the board's authority. The Houseman case shows that the board has used suspension as a tool even where there is only a single error; in that case, the board felt suspension was needed because the practitioner had failed to appreciate the significance of his misconduct. This case, though involving more serious and pervasive misconduct than Houseman, presents the same problem of a dentist who does not accept that what he did was wrong.

Based on the information Dr. Ness provided in this proceeding, he is likely correct about the adverse financial effect a suspension would have on him. However, discipline imposed against a licensee by the Board of Dental Examiners is not punishment. It furthers the regulatory goal of protecting the public from unfit practitioners and deterring the licensee at issue and other practitioners from engaging in similar conduct.[150] Moreover, adverse financial circumstances resulting from a licensee's discipline are not controlling factors to mitigate sanctions in this case.[151] In every case involving professional license suspension or revocation there are obvious and unavoidable pecuniary consequences to the licensee and, unfortunately, often to others.

Dr. Ness attempted an unduly risky surgical procedure, for which he was not sufficiently trained, on a patient whom he "was quite relentless"[152] in urging to undergo the procedure, misleading the patient regarding the effectiveness of the surgery and his qualifications to perform it. R.R. lost eight teeth and facial bone in his mandible and suffered substantial physical and emotional pain, in addition to the tremendous inconvenience of having to attend dozens of dental-related appointments over a half-year period. When the board commenced a disciplinary action, Ness initially took full responsibility, then recanted and changed his story at the hearing in several areas. He now contends that the questionable surgery he performed on R.R. with "tragic complications," to use his words from his letter to the board, is fully consistent with the professional standard in Alaska. The standard he seeks to implement includes not only the surgery itself, but aftercare including circumstances for referral.

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[150] Wendte, 70 P.3d at 1094.
[151] Matter of Hanlon, 110 P. 3d 937, 942-43 (Alaska 2005) (effect of three-year suspension on attorney's career, personal reputation, and family "are not mitigating factors").
[152] Exhibit 5, p. 1100010.

3. Appropriate sanction

Suspension in this case is justified based on any one of the violations that have been proven. Indeed, Dr. Robinson was suspended for what was, in essence, a less serious instance of the violation in Count III alone. Viewing the conduct in the aggregate together with the surrounding circumstances, a four month suspension is appropriate. The suspension should be followed by five years of probation with his practice subject to random audit by the board or its designee during each of the one-year periods after suspension.

The board has authority to fine a licensee up to $25,000 for each violation. A fine in this case will have some precedential value with the board, as AS 08.01.075(f) is applied in the future. Dr. Ness will likely suffer substantial pecuniary loss during a four month suspension. Consequently, only moderate fines are appropriate. He should be fined $5,000 for violating AS 08.36.315(6) under Count I, $5,000 for violating AS 08.36.315(6) under Count II, $5,000 for violating AS 08.36.315(6) under Count III, and $5,000 for violating AS 08.36.315(7) under in Count VI. The $5,000 fine for violating Count VI is suspended based on the condition stated in the next paragraph.

Due to the ethical violation, Ness should attend eight hours of continuing education on ethics, with the course(s) approved in advance by the board. Because the ethics violation is based on the same central facts involving the same patient as in Counts I, II, and III, completion of this ethics requirement to the satisfaction of the board will obviate the need to pay the fine arising from Count VI.

The suspension should take effect no later than 120 days from the final administrative order by the board. This will give Dr. Ness time to make some arrangements for his patients and office personnel. In considering a stay of the sanctions under AS 44.62.520 of the APA, the board should be guided by the likelihood that Dr. Ness may perform the surgery again.

V. Conclusion

Dr. Ness violated AS 08.36.315(6) as alleged in Counts I, II and III. Ness also violated AS 08.36.315(7) and 12 AAC 28.905(b) [considered one violation] as alleged in Count VI.

Disciplinary sanctions for Dr. Ness based on these violations, as addressed in the preceding section of the discussion, include license suspension, a fine for each violation, continuing education, and license probation including audit.

DATED this 19th day of April, 2006.

Signed
David G. Stebing
Administrative Law Judge

BOARD ACTION ON DECISION AND ORDER

The board having reviewed the proposed Decision and Order by the administrative law judge in: The Matter of **Douglas Ness,** OAH Case No. 04-0250-DEN, hereby

Option 1: adopts the proposed decision in its entirety under AS 44.62.500(b).

Date: May 2, 2006 By: Kevin Gottlieb, D.D.S.
Chairperson

Option 2: rejects the proposed decision under AS 44.62.500(c), and remands this case to the same/different administrative law judge to receive additional evidence on the following issues:

_____

_____

Date: _____ By: _____
Chairperson

Option 3: rejects the proposed decision under AS 44.62.500(c) and orders that the entire record be prepared for board review and that oral or written argument be scheduled in front of the board prior to final consideration of the decision in this case.

Date: _____ By: _____
Chairperson

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT

In the Matter of License No. 703,	)
Douglas G. Ness, D.D.S.,	)
Appellant,	)
vs.	)
	)
Alaska State Board of	)
Dental Examiners,	)
Appellee.	)
	)

Case No.3AN-06-8587CI

DECISION AND ORDER AFFIRMING FINDINGS AND CONCLUSIONS OF THE BOARD OF DENTAL EXAMINERS AND AFFIRMING THE SANCTIONS IMPOSED, IN PART, BUT REVERSING THE ORDER OF SUSPENSION

I: Introduction

This is an appeal from a May 2, 2006, Decision and Order of the Board of Dental Examiners adopting the proposed decision of the Administrative Law Judge (ALJ) in its entirety under AS 44.62.500(b). That decision found that Appellant, Dr. Douglas Ness, violated AS 08.36.315(6) because:

(1.) His performance of surgery on R.R. and his post-operative treatment did not conform to the minimum professional standard;

(2.) His treatment was unnecessary and the patient was not an appropriate candidate for the surgery;

(3.) The surgery was performed in a manner that fell below minimum standards of performance in the field of dentistry; and

(4.) His aftercare for R.R. fell below minimum standards when he failed to timely refer his patient to an appropriate specialist when the need arose.

The Board also adopted the sanctions proposed by the ALJ as follows:

(1.) A four month suspension, to be followed by five years of probation with his practice subject to random audit by the Board or its designee during each of the one-year periods after suspension;

(2.) Fines totaling $20,000.00 with $5,000.00 suspended on the condition that Ness attend eight hours of continuing education on ethics, to be approved in advance by the Board.

Dr. Ness appealed the Board's decision to this court, and oral argument was held on October 24, 2007. Because this Court understands that a higher court upon further review owes this Court no deference in its assessment of the findings and conclusions reached by the ALJ and adopted by the Board, this Decision and Order will not include an exhaustive review of those individual findings and conclusions. Having said this, this Court wants to make it very clear to the parties and to any reviewing court that it has spent hours reviewing and considering the original Board Decision and Order, as well as the briefing and oral argument presented on appeal.

In sum, while this Court has some concerns (which are expressed below) about the administrative process followed in this action, it finds that there is substantial evidence in the record to support the Board's decision to adopt a majority of the ALJ's findings and conclusions.

But this Court finds that the sanction of a four-month suspension for a first case of improper procedure in a seventeen year career constitutes an unwarranted punishment which does not assist in achieving the goal of instilling the respect and confidence of the public.

II: Discussion

On appeal, Dr. Ness presented the following three issues for review:

(1.) Whether the state erred under AS 08.01.075(f) in revoking Dr. Ness' license for 120 days and imposing a $20,000.00 fine for a single act of negligence involving one patient one time, where no other licensee in the history of the state (or the territory) was ever so severely disciplined, and whereas state law mandates "consistency in application of disciplinary sanctions."

(2.) Whether the ALJ applied the wrong standard of proof.

(3.) Whether there was a lack of evidence supporting the state's decision.

In response the Board identified the following as issues on appeal:

A. Whether the administrative law judge and the Board properly followed procedures under the Administrative Procedure Act?

B. Whether substantial evidence supports the Board's findings?

C. Whether the Board imposed a consistent disciplinary sanction pursuant to AS 08.01.075(f)?

D. Whether the administrative law judge applied the proper burden of proof?

E. Whether the administrative law judge or the Board erred at the May 2, 2006, teleconference meeting?

Substantial Evidence Supports the Board's Findings

The ALJ in this matter conducted a hearing which took place over a period of six days. Seventeen witnesses testified, and the hearing record consists of nineteen audiocassette tapes and a number of exhibits.

The essence of much of Appellant's argument on appeal is that the ALJ ignored and/or omitted a great deal of evidence and testimony which was favorable to Appellant. But a fair reading of the ALJ's forty-two page Decision and Order reveals that the ALJ considered and weighed the testimony and evidence presented to him, and that generally

the ALJ stated his reasons for giving greater or lesser weight to certain testimony and evidence. Therefore, this Court finds that there is substantial evidence in the record to support the ALJ's decision.

The ALJ Applied the Proper Burden of Proof

Although Appellant recognizes that the general Administrative Procedure Act standard for burden of proof is a "preponderance of the evidence," he argues that the standard in his case should have been by "clear and convincing evidence." Both parties cite AS 44.62.460(e)(1) which states that "unless a different standard of proof is stated in applicable law, the (1) petitioner has the burden of proof by a preponderance of the evidence if an accusation has been filed under AS 44.62.360 or if the renewal of a right, authority, license, or privilege has been denied."

Despite the argument made by Appellant on this issue, this court agrees with Appellee's assessment that "the Alaska Supreme Court has consistently held that the preponderance of the evidence standard, and not proof by clear and convincing evidence, is the appropriate standard in disciplinary proceeding." [1](Appellee's Brief, p.51)

The Administrative Law Judge and the Board Properly Followed Procedures Under the Administrative Procedure Act

Appellant argues that pursuant to AS 44.64.060(e) he should have been entitled to 30 days to file a proposal for action after the ALJ's proposed action was served. While this court has concerns about the procedure that was followed, it is persuaded by Appellee's counter-argument that AS 44.64.060(e) became law after the commencement of Appellant's and is therefore not applicable to his case.

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[1] Disciplinary Matter involving Walton, 676 P.2d 1078, 1085 (Alaska 1983); In re Robson, 575 P.2d 771, 776-77 (Alaska 1978).

Despite being persuaded by Appellant's counter-argument on this issue, this Court is concerned about an administrative process which seems to have stood fundamental principles of administrative procedure on their head. As stated above, the ALJ in this matter, who apparently has no particular expertise in the area of dentistry, conducted a six-day hearing on this matter. He heard the testimony of seventeen witnesses, considered a number of exhibits, and compiled a hearing record consisting of nineteen audio-cassette tapes.

On appeal, this matter was thoroughly and extensively briefed and argued to this court, which also has no particular expertise in the subject matter at issue.

But after the ALJ's Decision and Order was presented for review by the Board – the only link in the administrative chain with actual and extensive expertise in the area – Appellant does not seem to have been afforded any meaningful opportunity to provide input to the Board regarding the ALJ's Decision and Order. As Appellant pointed out on appeal, the ALJ submitted his Decision and Order to the Board on April 19, 2006. Just twelve days later, on May 2, 2006, the Board simply adopted the Decision and Order in its entirety.

While this court must concede that under the statutory and case law [2] applicable to Appellant's case he was apparently not entitled to make additional arguments or comments to the Board, it does not seem logical in light of his right to fully argue and brief these matters to two judges who have no expertise whatsoever in the area of dentistry. Further, the so-called "opportunity" to address the Board for only three

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[2] Storrs V. State Medical Board, 664 P.2d 547, 554 (Alaska 1983); Wendte v. State Board of Real Estate Appraisers, 70 P.3d 1089, 1095 (Alaska 2003).

minutes seems to be simply illusory, and not a true opportunity for meaningful input at all.

While the Sanctions Imposed Were Generally Appropriate, the Four-Month Suspension Constitutes Unwarranted and Unnecessary Punishment Under the Circumstances.

Both parties to this action recognize that the ultimate goal in fashioning appropriate sanctions is not punishment; the goal is to protect the public and to instill public respect and confidence. To this end, this Court understands that a five year period of probation, with Appellant's practice subject to random audit by the Board or its designee, is an appropriate and effective means of protecting the public and instilling public respect and confidence. Likewise, while this Court recognizes that there is no perfect measure in fashioning sanctions, the fines imposed can also be seen to achieve the desired goals. Finally, the requirement that Appellant attend eight hours of continuing education, with the course(s) approved in advance by the Board, is an appropriate method of protecting the public and instilling public confidence.

But the sanction of a 120 day suspension under the circumstances of a single case of malpractice in a seventeen-year career seems to constitute unwarranted and unnecessary punishment, pure and simple. And this punishment focuses not only on Appellant, but also on his staff, and ultimately upon that portion of the public comprised of his patients. Of particular note in this regard, is the fact that the patient in this case clearly holds Appellant in high esteem and does not believe that Appellant should be punished in this fashion.

The nub of the ALJ's concern seems to be that Appellant has not recognized his error, and that he might choose to perform the surgery again in the future. But no fair reading of Appellant's overall comments support this conclusion. In short, while Appellant may have explained why he believes that a dentist of his skill and training is capable of performing this procedure, there is no substantial evidence to support a conclusion that Appellant has any intention of ever attempting to perform this procedure. Further, even if the ALJ had this concern, there does not seem to by any rational relationship between this concern and the sanction of a four-month suspension. Again, this sanction does not appear to constitute any goal other than pure punishment.

As Appellant stated at page 18 of his Reply Brief,

> It remains undisputed that no dentist, no health care provider in this state, has ever been suspended for four months (or more) for a single incident of malpractice. It further remains undisputed that this is not a case of drugs, sex or dishonesty that has led other boards to suspend licenses for four months or more. Finally, it remains factually undisputed by the State that Dr. Ness mitigated the harm here with the patient (like the ALJ, the State refuses to recognize that the patient testified on behalf of Dr. Ness), took extraordinary measure at his own costs for hyperbaric treatment, and voluntarily resolved the matter promptly with the patient in order to make the patient whole.

III: Conclusion

Based upon a review of the briefing and argument presented by the parties to this action, and upon a review of the entire record herein,

IT IS HEREBY ORDERED that:

1. The decision by the board imposing a four-month suspension is **REVERSED** and
2. The findings and conclusions of the Board, including the decision to impose all other sanctions are **AFFIRMED.**

ENTERED this 28th day of April 2008 at Anchorage, Alaska

Signed
MICHAEL L. WOLVERTON
SUPERIOR COURT JUDGE