

BEFORE THE BOARD OF DENTAL EXAMINERS
STATE OF IOWA

IN THE MATTER OF :)	
)	
André Q. BELL, D.D.S.)	
207 E. Main St.)	FINDINGS OF FACT,
Knoxville, IA 50138)	CONCLUSIONS OF LAW,
)	DECISION AND ORDER
LICENSE NO. 7621)	
)	
Respondent)	
)	

TO: ANDRE Q. BELL, D.D.S.

On October 25, 2006, the Iowa Board of Dental Examiners (Board) filed a Notice of Hearing and Statement of Matters Asserted against André Q. Bell, D.D.S. (Respondent) charging him with:

Count I: Obtaining a fee by fraud or misrepresentation, in violation of Iowa Code section 153.34(5)(2005) and 650 IAC 30.4(10);

Count II: Failing to maintain a satisfactory standard of competency in the practice of dentistry, in violation of Iowa Code section 153.34(8)(2005) and 650 IAC 30.4(16); and

Count III: Willful or repeated violations of Board rule by failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, in violation of 650 IAC 30.4(35).

A hearing was initially scheduled for January 18, 2007 but was continued at Respondent's request. On or about March 5, 2007, the state filed a Motion To Amend Notice of Hearing and Statement of Matters Asserted, seeking to add two additional counts:

Count IV: Unprofessional conduct, in violation of Iowa Code section 153.34(7)(2007); and

Count V: Inability to practice dentistry with reasonable skill and safety by reason of illness, or as a result of a physical or mental condition.

Respondent did not file a Resistance to the state's Motion to Amend, and the Board delegated ruling on the motion to an administrative law judge. On March 22, 2007, a Ruling Granting Motion to Amend Notice of Hearing and Statement of Matters Asserted was issued and served on Respondent by restricted certified mail.

The hearing was held before the Board on April 17, 2007 at 12:30 p.m. in the Tone Conference Room, State Historical Building, Des Moines, Iowa. The following members of the Board presided at the hearing: Deena R. Kuempel, D.D.S., Chairperson; Richard M. Reay, D.D.S.; Gary Roth, D.D.S.; Alan Hathaway, D.D.S.; Debra Yossi, R.D.H.; Eileen Cacioppo, R.D.H.; and Suzan Stewart, Public Member. Respondent appeared in person and was self-represented. Assistant Attorney General Theresa O'Connell Weeg represented the state. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was recorded by a certified court reporter and was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1) and 650 IAC 51.34(3).

The Board, having heard the testimony and having examined the exhibits, and after convening in closed executive session pursuant to Iowa Code section 21.5(1)(f)(2007) to deliberate, directed the administrative law judge to prepare their Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the testimony of the witnesses; State Exhibits 1-63 (See Exhibit Index for descriptions of Exhibits 1-61; Exhibit 62 is the original radiographs and patient charts, Exhibit 63 is a February 14, 2007 letter from Theresa Weeg to Respondent)

FINDINGS OF FACT

Licensure and Disciplinary History

1. On November 2, 1992, Respondent was issued license number 7621 by the Board to engage in the practice of dentistry, subject to the laws of the state of Iowa and the rules of the Board. Respondent had practiced dentistry in the state of

Kansas for approximately ten years before moving to Iowa. (State Exhibit 5; Testimony of Respondent)

2. On April 17, 2003, the Board found probable cause to file a Statement of Charges against Respondent, charging him with willful or repeated violations of Board rule by failing to maintain records in a manner consistent with the protection of the welfare of the patient (Count I); obtaining a fee by fraud or misrepresentation (Count II); and unprofessional conduct (Count III). The Statement of Charges further alleged, in part, that Respondent violated Board rule by accepting a third-party payment under a co-payment plan as payment in full without disclosing to the third party payer that the patient's portion would not be collected. (Testimony of Phil McCollum; State Exhibit 1)

On September 15, 2003, Respondent and the Board entered into a Stipulation and Consent Order in resolution of the Statement of Charges. Respondent was represented by counsel and acknowledged that he read the Stipulation and Consent Order in its entirety, understood its content, and executed it freely, voluntarily, and with no mental reservation whatsoever. Pursuant to the Stipulation and Consent Order, Respondent's dental license was placed on probation for a period of two years, subject to conditions and monitoring related to Respondent's billing and record keeping practices. One of the conditions of probation specifically required Respondent "to fully cooperate in announced or random unannounced reviews or evaluations by the Board or agents of the Board." (Testimony of Phil McCollum; State Exhibit 2)

3. On October 25, 2004, the Board found probable cause to file a second Statement of Charge against Respondent, charging him with willful or repeated violations of Board rules by failing to maintain records in a manner consistent with the welfare of the patient (Count I) and failing to comply with a decision of the Board imposing licensee discipline (Count II). (Testimony of Phil McCollum; State Exhibit 3)

On January 14, 2005, Respondent and the Board entered into a second Stipulation and Consent Order, in resolution of the pending Statement of Charges. Respondent was represented by counsel at the time and voluntarily waived any objection to the Stipulation and Consent Order. Pursuant to the Stipulation and Consent Order, Respondent was issued a Citation and Warning. In

addition, Respondent's probation was extended to September 16, 2006, subject to conditions and monitoring related to patient record keeping and patient billing. The conditions of probation also required Respondent, in part, to submit to annual reviews of his patient record keeping and patient billing practices by Board consultants and to fully cooperate in announced or random unannounced reviews or evaluations by the Board or agents of the Board. (Testimony of Phil McCollum; State Exhibit 4)

Current Complaints- Billing and Insurance Issues

4. On May 16, 2006, the Iowa Insurance Fraud Bureau sent a copy of a suspected insurance fraud report to the Board. The report concerned Respondent's submission of a claim to Aetna Insurance Company for patient TG. The Board directed its investigator to conduct an investigation, gather records, and prepare a report. The Board's investigator obtained the patient's records, including radiographs and Respondent's billing records.¹ The investigator spoke to a representative from Aetna's Special Investigations Unit and to Respondent. Respondent submitted a written response to the investigator's questions concerning the billing. Board Consultant John Campbell, D.D.S. reviewed the billing and insurance records and issued a Consultant Report on June 12, 2006. Based on a review of all of the evidence, the Board makes the following findings:

a. On June 10, 2005, Respondent performed a core build-up² (service code-D2950) on tooth #15 and on or about June 23, 2005, Respondent submitted a \$138.00 claim to Aetna Insurance for this procedure. On July 4, 2005, Aetna issued an Explanation of Benefits (EOB) denying payment on the claim because the member's benefits did not cover the procedure. The copy of the July 4,

¹ In letters sent to the Board office and at the hearing, Respondent challenged the Board's authority to obtain copies of his patient records. The Board was authorized to obtain these records and Respondent was required to fully cooperate in unannounced and or random unannounced reviews or evaluations by the Board or agents of the Board, pursuant to the express terms of the Stipulation and Consent Orders between Respondent and the Board establishing conditions of his probation. (State Exhibits 2, 4). In addition, the Board has statutory authority to subpoena records, whether or not privileged or confidential under state law, which are deemed necessary as evidence in connection with a disciplinary proceeding. Iowa Code sections 17A.13(1), 272C.6(3) and 650 IAC 31.5.

² A core build-up is a procedure performed to build up the tooth with filling material when a dentist is planning to place a crown but there is inadequate tooth core remaining to anchor the crown. (Testimony of Dr. John Campbell, D.D.S.)

2005 EOB found in Respondent's patient file bore a handwritten note stating, "I think we should resubmit as a 4 surface filling." From the record, it appears that Respondent resubmitted the exact same claim to Aetna for a core build-up (Code D2950) on July 22, 2005.

b. On August 1, 2005, Aetna sent Respondent a letter asking him to submit his 2005 chart notes for TG and his pretreatment x-ray for tooth #15. Respondent's chart notes indicate that on 6/10/05 the patient was seen for a broken tooth, Respondent performed a "build-up," and the patient was told he could leave the tooth as it was and risk losing the tooth or have a crown placed. An additional note to the chart indicates that the patient chose option 1, leaving the tooth as it was.

c. On August 8, 2005, Aetna sent a second EOB denying payment on the claim for a core build-up, but with the added remark: "These expenses require further review." The copy of this EOB that was found in Respondent's file had the following handwritten notes, presumably written by Respondent: "Let me look at his chart," "Call them & ask if they will pay for a 4 surface amalgam on tooth #15. If they will, make it a MODF and resubmit," and "15-MOFL Amalgam -111- yes."

d. On or about August 9, 2005, Respondent resubmitted a claim for the patient for a four surface filling (service code-D2161) on tooth #15 on 6/10/05 and a charge of \$138.00. As reflected in an August 29, 2005 EOB in the patient's file, Aetna denied the claim with the following explanation: "Based on the information received, these services were not provided. If there is additional information that should be brought to our attention please contact us."

e. Respondent later submitted another claim for a four surface MOFL filling (service code-D2161) for tooth #15 with a service date of 8/10/05 and a charge of \$111.00. In the copy of the claim form in Respondent's file, it is obvious that at one time the 6/10/05 date of service was altered to 8/10/05 and then later changed back to a 6/10/05. Respondent signed the claim form on August 18, 2005. This claim form was submitted to Aetna and eventually paid by them. There was also another claim form in Respondent's file, purportedly signed by Respondent on June 17, 2005, which showed a four surface MODL silver amalgam on

tooth #15 on 6/10/05 with a charge of \$111.00, but this form was never submitted to Aetna.

f. Respondent did not provide any dental treatment to the patient on 8/10/05.

g. On October 3, 2005, Aetna issued an EOB paying a claim for a four surface filling (MOFL) on tooth #15 with a service date of 8/10/05. The claim was for \$111.00 and Aetna paid Respondent \$48.40, leaving a patient balance of \$62.60. An Aetna representative told the Board's investigator that the claim was paid in error, apparently because it appeared to be a brand new claim.

(Testimony of Phil McCollum; John Campbell, D.D.S.; Respondent; State Exhibits 14-18 56, 57)

5. The ledger for patient TG reflects that Respondent wrote off the patient's portion of the bill (\$62.60) on April 10, 2006. Respondent admits that he never notified Aetna that the patient's portion of the bill would not be collected, as required by Board rule and professional ethics. Respondent initially told the Board's investigator that the patient was having financial difficulties, and he wrote it off to be nice to him. At the hearing, Respondent testified that he wrote the bill off because he had sent several statements to the patient, but the bill was never paid. The patient's ledger has handwritten entries indicating that statements were sent to the patient before the balance was written off, but most of these entries appear following the write-off line on April 10, 2006. (Testimony of Phil McCollum; John Campbell, D.D.S.; State Exhibits 14-18, 56, 57)

Professional Competency

6. Between June and September 2006, three of Respondent's employees and one of his patients filed complaints with the Board concerning the quality of Respondent's dentistry. Respondent was still on probation, and receipt of the complaints prompted the Board to initiate a review of Respondent's practice, pursuant to paragraph 5 of the January 14, 2005 Stipulation and Consent Order. The Board's investigator obtained copies of Respondent's patient records, which were forwarded to Board consultant John Campbell, D.D.S. (Testimony

of Phil McCollum; John Campbell, D.D.S.; State Exhibits 4, 19-26)

7. On July 31, 2006, Dr. Campbell issued a Consultant Report based on his review of patient records and radiographs for twenty of Respondent's patients. Dr. Campbell found that Respondent's treatment of seven of the twenty patients fell below the acceptable standard of care. (State Exhibits 17, 27; Testimony of John Campbell, D.D.S.)

a. Dr. Campbell's biggest concern was Respondent's placement of crowns.³ In four of the records reviewed by Dr. Campbell, Respondent placed a crown for try-in, either with no cement or with temporary cement, but was then unable to remove the crown with his fingers. In all four cases, Respondent sent the patient home without taking any additional measures to try to remove the crown and permanently cement it. Dr. Campbell concluded, and the Board agrees, that Respondent failed to conform to the minimum standard of care when he failed to cement crowns. Respondent's treatment could put the patient's health at risk because if the crown came off, the patient could aspirate it, thereby causing a serious pulmonary condition. In addition, the Board had very serious concerns that even if the crown did not come off unexpectedly, these patients were placed at increased risk for caries. (State Exhibits 27; 29; 31; 37; 47; 62)

b. Dr. Campbell also concluded that Respondent failed to conform to the acceptable standard of care when he failed to properly diagnose decay in tooth #29⁴ for patient E.S. The Board reviewed the original x-rays and agrees with Dr. Campbell's conclusion and reasoning. The dental decay was clearly visible on the August 6, 2004 x-ray and any minimally competent dentist should have diagnosed the decay at that time. The Board members could see the decay in prior x-rays as well. The decay was still clearly visible in the x-ray on August 5, 2005, but remained undiagnosed by Respondent. Respondent did not diagnose the decay until June 16, 2006. At that time, he advised the patient that she might need a root canal. The failure to timely

³ Although Dr. Campbell initially raised concerns about Respondent's billing for crowns, at hearing Dr. Campbell explained that he no longer had concerns about the billing.

⁴ Dr. Campbell's report cites the correct tooth number but the tooth number given in paragraph 3(b) of Statement of Matters Asserted was a typographical error.

diagnose the decay clearly allowed the patient's condition to worsen. (State Exhibits 27; 38; 62)

c. Dr. Campbell also concluded, and the Board agrees, that Respondent failed to conform to the acceptable standard of care when he left an alarming number of overhangs after restoring teeth for patient RH. The overhangs could lead to recurrent decay and periodontal problems for the patient. (State Exhibits 27; 39; 62)

d. Dr. Campbell was also concerned about Respondent's failure to remove or treatment plan the removal of a retained root tip for patient CC. However, the Board did not agree that the failure to remove the retained root tip violates the acceptable standard of care. (State Exhibits 27; 40; 62)

8. On October 10, 2006, Dr. Campbell issued a second consultant report after reviewing seven additional patient records and radiographs. Dr. Campbell found, and the Board agrees, that Respondent's treatment of one of the seven patients fell below the acceptable standard of care. Respondent failed to properly diagnose decay in tooth #12 for patient BP. Decay was obvious in the patient's x-ray on January 16, 2004 but Respondent failed to diagnose the decay until August 17, 2006, even though the patient was examined five times in this time period. When Respondent restored the tooth, he provided a large restoration because the patient could not afford a crown. The Board notes that Respondent did not document that he presented the patient with other options. Most importantly, Respondent left an open contact (space) between tooth #12 and tooth #13. It was a violation of the acceptable standard of care to leave this open contact because debris and bacteria can be trapped in the space, leading to further decay. Respondent's rationale for leaving the open contact area made no sense to either Dr. Campbell or the Board. (State Exhibit 48; 54; 59; 62; Testimony of John Campbell, D.D.S.; Respondent)

Compliance With Standard Infection Control Precautions

9. On August 14, 2006, Respondent's dental assistant e-mailed the Board's investigator to report an incident that occurred while she was assisting Respondent with a dental procedure. Respondent's dental assistant provided credible testimony concerning the incident at the Board hearing. On August 14, 2006 at approximately 11:00 a.m., Respondent replaced the high-

speed drill in its holder after filling a patient's tooth. When reaching for his mirror and explorer, Respondent scraped his right arm on the burr of the drill, cutting his arm and drawing blood. Respondent did not excuse himself to tend to the cut nor did he disinfect the instruments or the treatment area. Respondent examined the drill and then continued to use it on the patient. When he leaned over to check the patient's mouth, he dripped some blood on the instrument table. Respondent did nothing to address the presence of blood in the treatment area or to protect the patient or dental assistant. The patient was never notified of the exposure. The dental assistant used a paper towel and disinfectant to clean the blood off the instrument table.

The dental assistant had been studying and preparing for her dental assistant examinations required for registration and realized that Respondent's actions violated the standard precautions for preventing and controlling infectious diseases. At lunch, the dental assistant reported the incident to the dental hygienist, and that afternoon the dental hygienist saw Respondent with a 2x2" bandage above his elbow area. Later, Respondent spoke to the dental hygienist about the patient and told the dental hygienist, "It's [her] word against my word and if I'm asked about it I'm denying it."

Respondent did not testify concerning this incident. In his written response to the Board's investigator, Respondent admitted scraping his arm against the burr of the drill causing a "tiny break" in the skin. Respondent claimed that he was 2-3 feet away from the patient when this occurred, and there was no risk of exposure to the patient. Respondent further claimed that he left the operatory, cleaned the scratch on his arm with two alcohol gauze pads, removed his gloves, washed his hands, and put on new gloves before treating any patient. Respondent claims that he used the low-speed hand piece and burr to finish treating the patient. However, the sworn testimony of the dental assistant and the dental hygienist was more credible than the conflicting hearsay statements of Respondent.

As explained by Dr. Campbell, Respondent's obligation was to stop the dental procedure, clean and dress his wound, sterilize or replace the instruments, and inform the patient of the exposure and the availability of follow-up testing for blood-borne illnesses. (Testimony of Lori Hutchinson; Robin Spencer; Phil McCollum; John Campbell, D.D.S.; State Exhibits 60, 61)

Unprofessional Conduct/Mental Health Concerns

10. On January 25, 2007, Respondent sent the Board's investigator, Phil McCollum, a six-page letter entitled "Official Notice," which accused McCollum, in part, of corrupt acts, attempted extortion, mail fraud, wire fraud, and deprivation of intangible Right of honest services, and Violation of Oath of Office. The letter was sent to the Board's office. In the letter, Respondent challenges the Board's authority to regulate his practice of dentistry and to subpoena patient records and tells Mr. McCollum that he has "...willfully and maliciously ignored the laws you are required by those Constitutions to give oath or affirmation to uphold. Proceed at your own peril. Sic semper tyrannis."

Phil McCollum has previous law enforcement experience, and he recognized that the content of Respondent's letter was very similar to communications that have been sent to governmental agencies by members of an anti-government group known as "Posse Comitatus."⁵ An assistant attorney general who was familiar with the activities of Posse Comitatus in Iowa agreed with Mr. McCollum's assessment. Mr. McCollum perceived Respondent's letter as a direct threat. Mr. McCollum explained that the Latin phrase, "sic semper tyrannis,"⁶ has been used throughout history by persons willing to engage in violent acts to support anti-government positions. (Testimony of Phil McCollum; State Exhibit 9)

11. Respondent's letter was submitted to a board-certified psychiatrist, along with the three Statements of Charges that had been filed against Respondent. The psychiatrist was asked to provide the Board with any opinions he had regarding the letter and to address whether he had any concerns regarding the professionalism and state of mind of the author. In a letter dated February 25, 2007, the psychiatrist states that the "overall tone" of Respondent's letter, and the rather "rambling and disorganized" manner in which he argues his case, should raise concerns for the Board about Respondent's "professionalism and

⁵ Posse Comitatus is actually a federal act from the late 1800's that prohibits military personnel from being used for non-military law enforcement purposes. However, it is also the name of an anti-government group that became quite active in Iowa during the farm crisis and that renounces the authority of government and the police. (Testimony of Phil McCollum)

⁶ Thus always to tyrants.

state of mind." The psychiatrist notes that Respondent's statement that his "patience is wholly and completely exhausted" appears to be an understatement. (Testimony of Phil McCollum; State Exhibit 13)

12. On February 28, 2007, Respondent sent a second similar letter to Phil McCollum at the Board office, which states in part:

...Spiritual law and your Right to be considered innocent until proven guilty have required me to allow you the time and opportunity to confess your error, begin restitution of the damages you have wrongfully inflicted upon my person, property, and good name, and otherwise show contrition. Your continued failure to do so shall be deemed prima facie evidence of your malevolent intent initially and continued recalcitrance, both relieving me of any responsibility of restraint...

(Testimony of Phil McCollum; State Exhibit 10)

13. On March 2, 2007, Respondent sent a third letter to the Board's offices. This letter was addressed to Theresa Weeg, the state's legal representative in the disciplinary proceeding. This six-page letter was very similar in content to both letters addressed to Phil McCollum, including the reference to "sic semper tyrannis." In his closing, Respondent states:

...The cost of your hubris and violations of your oath shall be expensive to you. My patience is wholly and completely exhausted. Proceed at your own peril, for if your superiors allow your vendetta to continue, they shall go down with you.

(Testimony of Phil McCollum; State Exhibit 11)

CONCLUSIONS OF LAW

Authority of the Board

The legislature has created the Iowa Board of Dental Examiners and has authorized the Board, in part, to:

- Administer and enforce the laws relating to the dental profession;
- Adopt and enforce administrative rules;
- Review or investigate, or both, upon written complaint or upon its own motion pursuant to other evidence received by the board, alleged acts or omissions which the board reasonable believes constitutes cause under the applicable law or administrative rule for licensee discipline; and
- To initiate and prosecute disciplinary proceedings.

Iowa Code sections 272C.3; 272C.1(6)(j).

The Board is authorized by statute to issue subpoenas to compel the production of professional records, books, papers, correspondence and other records, whether or not privileged or confidential under law, which are deemed necessary as evidence in connection with a disciplinary proceeding. Iowa Code section 272C.6(3).

Finally, the Board is authorized, following a hearing or pursuant to an informal settlement with a licensee, to impose licensee discipline, including, in part, revocation or suspension of a license, requiring additional education or training, or placing a license on probation under specified conditions. Iowa Code section 272C.3(2), (4); 650 IAC 30.2.

Applicable Statutes and Rules

Iowa Code section 153.34(5)(2005), (2007) provides, in relevant part:

153.34 Discipline

The board may issue an order to discipline a licensed dentist... for any of the grounds set forth in this chapter, chapter 272C, or Title IV. Notwithstanding section 272C.3, licensee or registrant discipline may include a civil penalty not to exceed ten thousand dollars. Pursuant to this section, the board may

discipline a licensee or registrant for any of the following reasons:

...

4. For willful or repeated violations of this chapter, this subtitle, or the rules of the state board of dentistry.

5. For obtaining any fee by fraud or misrepresentation.

...

7. For ...dishonorable or unprofessional conduct in the practice of dentistry...

8. For failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry or dental hygiene.

...

14. Inability to practice dentistry...with reasonable skill and safety by reason of illness,...or as a result of a mental or physical condition...

650 IAC 30.4(16) provides in relevant part:

650-30.4(153) Grounds for discipline. The following shall constitute grounds for the imposition by the board of one or more of the disciplinary sanctions set forth in rule 650-30.2(153) specifically including the imposition of civil penalties not to exceed \$10,000.

...

10. Obtaining any fee by fraud or misrepresentation.

16. Failure to maintain a reasonably satisfactory standard of competency.

...

35. Failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

Count I

The preponderance of the evidence established that Respondent obtained a fee by fraud or misrepresentation, in violation of Iowa Code section 153.34(5)(2005) and 650 IAC 30.4(10), when he

attempted to make a non-covered procedure appear to be a covered procedure by altering the date of service and when he accepted a third-party payment as payment in full without disclosing to the third-party payer that the patient's portion would not be collected.

The Board's consultant and the Board agree with Respondent's assertion that a "core build-up" and a four surface filling are essentially the same procedure. The primary difference is that a core build-up is a preliminary step to placement of a crown. When the insurance company rejected the initial claim for a "core-build-up" because it was not covered under the patient's policy and when the patient elected not to proceed with a crown, it was appropriate for Respondent to resubmit the claim as a four-surface filling, so long as the date of service was correct. Respondent should have explained to the insurance company that the patient elected not to go forward with the crown. If the insurance company continued to deny the claim, the patient could have asked the insurance company to review its decision or could pay Respondent's fee himself.

However, it was completely inappropriate for Respondent to resubmit the claim to the insurance company with an altered/incorrect date of service. Board rules provide that a dentist who submits a claim form to a third party reporting incorrect treatment dates is engaging in making unethical, false or misleading representations. 650 IAC 27.7(5). The only purpose in altering the date of service was to mislead the insurance company into believing that this was a different procedure than the one that was previously denied payment. Respondent's claim that this was a clerical error was not credible.

In addition, Respondent should have informed the insurance company that he was accepting the insurance payment as payment in full and would not be collecting the co-payment from the patient. Board rules provide that it is deception and misrepresentation for a dentist to accept a third-party payment plan as payment in full without disclosing to the third-party payer that the patient's payment portion will not be collected. 650 IAC 27.7(2). Respondent was previously disciplined for this same violation. (State Exhibit 1) Respondent's claim that he sent eight unanswered statements to the patient and was merely writing off a bad debt was not credible. The Board was not convinced that the entries documenting that billing statements

were sent were made on the dates reflected. In addition, the patient had a good payment history prior to the write-off.

Count II

The preponderance of the evidence established that Respondent has failed to maintain a satisfactory standard of competency in the practice of dentistry, in violation of Iowa Code section 153.34(8)(2005) and 650 IAC 30.4(16). Respondent repeatedly failed to properly cement crowns, repeatedly failed to properly diagnose decay, and repeatedly failed to provide proper restorations. Respondent's failure to provide dental treatment in conformance with the minimum standard of care placed his patients at increased risk for decay and periodontal problems. Respondent's inappropriate proposal to use Vaseline for crown try-ins raises additional concerns about his competence and his professional decision-making.

Count III

The preponderance of the evidence established that Respondent violated Iowa Code section 153.34(4)(2005) and 650 IAC 30.4(35) when he willfully violated the rules of the Board by failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended for dentistry by the Centers for Disease Control of the United States Department of Health and Human Services (CDC). Respondent cut himself on a drill, drawing blood, but continued to treat the patient without stopping to wash and treat his injury and or disinfect the instruments and affected treatment area.

Count IV

The preponderance of the evidence established that Respondent committed unprofessional conduct, in violation of Iowa Code section 155.34(7)(2007) and as defined by 650 IAC 27.9⁷, when he wrote threatening and harassing letters to the Board's investigator and to the assistant attorney general representing the state in his disciplinary proceeding. The tone and content

⁷ 650 IAC 27.9(1) provides that licensee or registrant actions determined by the board to be abusive, coercive, intimidating, harassing, untruthful or threatening in connection with the practice of dentistry shall constitute unethical or unprofessional conduct.

of the letters went far beyond any legitimate purpose of presenting a defense or preserving or advancing Respondent's legal rights. Respondent sent the letters with the obvious intent of undermining the Board's disciplinary process by attempting to intimidate two state employees with blatant threats of financial harassment and implied threats of physical harm.

Count V

Respondent's three letters, the psychiatrist's review of those letters, and Respondent's demeanor at hearing raise serious Board concerns about whether Respondent may suffer from a physical illness or a mental condition affecting his ability to safely practice dentistry. In addition to their inappropriate and threatening tone and content, Respondent's letters ramble and appear to reflect a disorganized thought process. In his cross-examination and presentation at hearing, Respondent focused almost exclusively challenging the authority of the Board and its investigator to investigate complaints and obtain patient records. Respondent was frequently agitated and hostile during his questioning of the Board's investigator and other witnesses. Respondent repeatedly referred to his "experts" upon whose advice he was relying but whose names he stated "he would never reveal." At one point, Respondent appeared especially agitated and abruptly left the hearing room without warning or explanation. While the Board was undecided whether there was sufficient evidence upon which to find a violation of Iowa Code section 153.34(14), it was clear to the Board that it has probable cause to order a physical and mental health evaluation, pursuant to its authority under Iowa Code section 272C.9(1)(2007). If Respondent refuses to submit to the mental health evaluation, the Board is authorized to order that the allegations pursuant to which the mental examination was ordered shall be taken as established.

DECISION AND ORDER

IT IS THEREFORE ORDERED that dental license no. 7621, issued to Respondent André Q. Bell, D.D.S., shall be immediately suspended effective upon service of this Order. Respondent shall immediately cease and desist from the practice of dentistry until further Order of the Board. IT IS FURTHER ORDERED that prior to filing an application for reinstatement of his license, Respondent must comply with the following terms and conditions:

A. Pursuant to Iowa Code section 272C.9(1)(2007), Respondent shall complete a comprehensive physical, psychological, and psychiatric evaluation at a facility prior approved by the Board. Respondent shall notify the Board office at least fourteen (14) days prior to presenting to said facility. Respondent shall sign releases to allow for the free flow of information between the Board and the evaluators, counselors and physicians. Respondent shall comply with any recommendations of the evaluating facility. Any subsequent treatment programs/providers shall be prior approved by the Board. All costs associated with the evaluation and compliance with any recommendations shall be the sole responsibility of Respondent.

B. Respondent shall complete a comprehensive clinical assessment at a college of dentistry prior approved by the Board to determine his level of competency. Respondent shall notify the Board office at least fourteen (14) days prior to presenting at said facility. The university shall report the results of the assessment directly to the Board. All costs associated with the evaluation and compliance with any recommendations shall be the sole responsibility of Respondent.

Following completion of these requirements, Respondent may apply for reinstatement of his dental license. The burden of proof will be on Respondent to establish that the reason for the indefinite suspension no longer exists and that it is in the public interest for his license to be reinstated. 650 IAC 51.34(4). Upon a determination that Respondent is safe to return to practice, his dental license will be reinstated subject to terms of probation, including but not limited to monitoring for billing practices and patient care.

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

Page 18

Dated this 10th day of May, 2007.

Deena R. Kuempel, D.D.S.

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

cc: Theresa O'Connell Weeg
Office of the Attorney General
Hoover Building
Des Moines, Iowa 50319

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