STATE OF VERMONT
BOARD OF DENTAL EXAMINERS

IN RE:	**Peter A. Lakatos**	)
		) **DOCKET NOS.: DE10-1100,**
		) **DE13-1100, DE21-0201, DE09-1100,**
		DE24-0201, DE 01-0701, DE 32-0301

STIPULATION AND CONSENT ORDER

NOW COMES the State of Vermont through Prosecuting Attorney Robert H. Backus, and Peter A. Lakatos, D.M.D., in person and through counsel, Kaveh S. Shahi, and enter into the following Stipulation and Consent Order for approval by the Board.

Statement of Purpose

This matter has been pending in excess of six years. All except one of the charges filed against the Respondent in 2001 related to endodontic work. During the period of October 2003 to April 2004, the Respondent completed a number of continuing education courses in the field of endodontics. The Respondent resumed providing endodontic therapy in December 2005. Since then no complaints have been received by the Office of Professional Regulation as a result of his resuming providing endodontic therapy. Respondent has complied with this Board's requirements imposed earlier in this matter. The Respondent has asserted defenses to the Charges and these proceedings. However, in the interest of resolving this longstanding matter and to be able to continue his dental practice unhindered by the demands of this litigation, the Respondent is prepared to reach a voluntary resolution. Therefore, the parties agree as follows with the understanding that the rejection by the Board of any portion of this stipulation shall render the entire stipulation null and void.

Stipulation

1. With the exception of counts 1 and 8, which have been withdrawn, the Respondent shall not contest the Board finding that he violated 26 V.S.A. §809(a)(14) as to counts 2, 3, 4, 6, and 7, and §809(a)(1) as to count 5.

2. Specifically, as to count two (patient B.T.), count three (patient J.C.), count four (patient D.W.), count six (patient T.S.), and count seven (patient D.N.) the Board finds that the endodontic treatment provided by the Respondent during the period of 1996 to 2000 failed to meet the standard of an ordinary, careful and prudent dentist engaged in similar practice under the same or similar circumstances. 26 V.S.A. §809(a)(1).

3. In count 5 (patient H.K.) the Board finds that the Respondent in 1999 improperly failed to complete the patient's bridge work for failure to pay in violation of 26 V.S.A. §809(a)(14).

4. By way of sanctions, the Respondent's license shall be conditioned to require him to take at least twenty hours of ADA approved dental educational courses in endodontics. These courses shall be completed within 30 months of the entry of an Order upon this Stipulation. Respondent shall provide satisfactory proof of the successful completion of these courses to the Board or its designee within three years of the date of the entry of an Order upon this Stipulation.

5. Other than the condition specified above, the Respondent's license is not subject to any other sanctions or limitations.

6. The Respondent voluntarily enters this Stipulation after the opportunity to consult with legal counsel and without undue coercion. The State and Respondent waive the right to appeal from the Order entered upon this Stipulation.

ORDER

A. The Respondent violated 26 V.S.A. §809(a)(14) as to counts 2, 3, 4, 6, and 7, and 26 V.S.A. §809(a)(1) as to count 5 of the Specification of Charges filed in

this matter.

B. By way of sanctions, the Respondent's license shall be conditioned to require him to take at least twenty hours of ADA approved dental educational courses in endodontics. These courses shall be completed within 30 months of the entry of an Order upon this Stipulation. Respondent shall provide satisfactory proof of the successful completion of these courses to the Board or its designee within 30 months of the date of the entry of an Order upon this Stipulation.

C. Respondent's license is suspended for six months with credit for six months previously served. The Respondent's period of suspension has been completed and no additional suspension is created by this order.

D. Upon proof, reasonably acceptable to the Board, or its designee, of compliance with this Order, the condition shall be removed from Respondent's license.

E. This Stipulation and Order shall be a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

F. This Stipulation shall remain part of the Respondent's licensing file and may be used for purpose of determining sanctions in any future disciplinary matter.

DATED: April 8, 2008.

RESPECTFULLY SUBMITTED,

OFFICE OF PROFESSIONAL REGULATION

By: _____
Robert H. Backus, Esq.
State Prosecuting Attorney

CLEARY SHAHI & AICHER, P.C.

By: _____
Kaveh S. Shahi, Esq.
Attorney for Respondent

Peter A. Lakatos, D.M.D.

By: _____
Peter A. Lakatos D.M.D.

APPROVED AND SO ORDERED:

Dated: April 8, 2008

Date of entry: 4/8/08

Board of Dental Examiners

by: _____
Chairperson

STATE OF VERMONT
BOARD OF DENTAL EXAMINERS

IN RE:	Peter A. Lakatos License No. 16-0598	))Docket Nos.:))	DE10-1100, DE13-1100, DE21-0201, DE32-0301 DE09-1100,, DE24-0201 & DE01--0701

SPECIFICATION OF CHARGES

1. The Board of Dental Examiners has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by dentists pursuant to 3 V.S.A. §§129 and 129a, and 26 V.S.A. §§767 and 809.

2. Respondent, Peter A. Lakatos, of Rutland, Vermont, is a dentist, holding license number 16-0598 issued by the State of Vermont.

3. Respondent maintains a practice in dentistry in Rutland, Vermont and has done so during the period covered by these charges.

COUNT ONE / BAKER COMPLAINT

4. On or about 11/19/97 Respondent saw Marcia Baker as a patient. On that occasion he took an impression for a temporary bridge. The temporary bridge was placed on 1/8/98.

5. On 2/23/98, 4/08/98, 4/14/98, 4/27/98, 5/13/98 this temporary bridge was re-cemented.

6. On or about 6/17/98 Respondent took the final impression for Baker's permanent bridge. The bridge was tried on 7/21/98 and temporarily seated on 8/05/98.

7. On or about 8/19/98 a porcelain fracture on the permanent bridge was noted. Respondent sent the bridge back to the lab on 9/01/98.

8. On or about 9/22/98 Respondent reseated Baker's permanent bridge. It was discovered on this date that the bridge was again fractured.

9. On or about 1/07/99 Respondent removed this permanent bridge and sent it to the lab for repair of the previously discovered fracture.

10. On or about 2/02/99 Respondent seated temporarily the permanent bridge.

11. On or about 9/07/99 Respondent treated Baker for a complaint of possible fracture. He smoothed a fracture on #15.

12. On or about 10/13/99 Respondent again saw Baker for a fracture of the porcelain.

13. On or about 1/04/01 Respondent sent Baker's bridge back to the lab for repairs.

14. On or about 2/26/01 Respondent took an impression for a new temporary bridge and seated temporarily the old permanent bridge.

15. Throughout this course of treatment Respondent used the same impression of Baker's teeth.

16. The Respondent should have been aware that repeatedly using the same impression of Baker's prepared teeth could not possibly have produced a different result. Repeated failures of the bridge and the failure to take appropriate measures to prevent this from recurring are deviations from the standard of practice.

17. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree

of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

COUNT TWO / TOWSLEY COMPLAINT

18. Paragraphs 1 through 3 above are re-alleged.

19. On or about 4/16/98 Bryce Towsley saw Respondent about a tooth that had broken, tooth #19. Respondent indicated that a post and crown were necessary and proceeded to place a post in tooth #19.

20. Tooth #19 was perforated during preparation for installing a post. Respondent either failed to note this perforation or disregarded it and proceeded with treatment. The post installed by Respondent perforated the mesial surface of the distal root of tooth #19.

21. Respondent should have been aware of this perforation and taken appropriate steps. Failures to note this perforation and to take appropriate steps are deviations from the standard of practice.

22. Towsley informed Respondent that the tooth developed an abscess. Respondent treated this with antibiotics. The abscess would go away but return. Respondent's records confirm he was aware of repeated episodes of infection and toothache associated with tooth #19 and that the tooth was treated with antibiotics.

23. Respondent should have known that repeated infections following placement of a retentive endodontic post in tooth #19 were not normal and that a diagnosis and appropriate treatment were required.

24. Respondent's failure to appropriately diagnose and treat this repeated infection is a deviation from the standard of practice.

25. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

COUNT THREE / CROFOOT COMPLAINT

26. Paragraphs 1 through 3 above are re-alleged.

27. In September of 1996 Jane Crofoot became a patient of Respondent and on or about 7/27/00 Respondent saw Jane Crofoot. Crofoot came in that day with a fracture to tooth #3. Respondent on that occasion performed endodontic treatment of tooth #3. Patient records fail to support the need for endodontic treatment of tooth #3. This is a deviation form the standard of practice.

28. On that occasion, 7/27/00, Respondent fractured an endodontic instrument (file) which lodged in and beyond the apical portion of one of the roots of tooth #3.

29. A radiograph taken post treatment shows this file fragment lodged in and protruding from the apex of the mesiobuccal root of tooth #3.

30. Excessive and inappropriate instrumentation of the apical portions of a root canal system are deviations from the standard of practice.

31. This radiograph also shows endodontic obturating material extending approximately 3 mm beyond the apex of the palatal root of tooth #3. This indicates over instrumentation of the apex and excessive overfilling.

32. Over instrumentation and excessive overfilling of the root canal system into the periradicular tissues is a violation of proper endodontic treatment protocols and deviates from the standard of practice

33. Post treatment radiographs of Crofoot's tooth #18 taken 8-4-98 and 3-10-99 show significant extension of the obturating material through the apical foramina of all three canals into the periapical tissue. The width of the material in the region of the apical foramina or each root canal indicates significant over-instrumentation in each case. This constitutes deviation from the standard of practice.

34. Respondent's records indicate that a retentive post was placed in tooth #18. The radiographs of tooth #18 show what may be a post in the distal root, but not a metal post. Either no post was placed, or a non-metal post was placed. If it is a post, it extends beyond the apex of the distal root. This is a deviation from the standard of practice. If it is obturating material it indicates over instrumentation of the apical portion of that root. This is also a deviation from the standard of practice.

35. There is visible space lateral to the material in the distal canal of tooth #18 indicating an incomplete seal in the midroot portion of that canal.
This is a deviation from the standard of practice.

36. Radiographs taken of Crofoot's tooth #19 taken 2/11/98 and 3/10/99 evidence a probable perforation of the mesial root by an endodontic retentive post. The post appears to perforate the mesial surface of that root and there is an extensive radiolucency in the interradicular area adjacent to the apparent perforation. This is a deviation from the standard of practice.

37. Radiographs of tooth #31 taken 7-1-97 and 7-8-97 evidence excessive instrumentation of the apical portions and beyond the roots into the periapical tissues of all the canals of that tooth and perforation of the mesial root of that tooth

at a point approximately 3 mm from its apex. This is a deviation from the standard of practice.

38. Additionally, Respondent repeatedly failed to address the existence of obvious disease associated with teeth #18 and #19 as evidenced by radiographs taken on 12/10/98 and 3/10/99. This is a deviation from the standard of practice.

39. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

COUNT FOUR / WISCH COMPLAINT

40. Paragraphs 1 through 3 above are re-alleged

41. On or about 5/27/98, Respondent saw patient Daryl Wisch. Respondent performed a root canal on tooth #5 of Ms. Wisch and inserted a post.

42. A comparison of radiographs taken before and after Respondent's treatment show that the apical constriction and root end of tooth #5 were destroyed in the course of Respondent's treatment, and that the post preparation extended the full length of the root and into the periapical tissue.

43. Destruction of the apical structure of a root is a deviation from the standard of practice.

44. Respondent knew or should have known that he had removed all of the endodontic apical seal and cut through the root apex. Failure to recognize this and

inform the patient and to take appropriate remedial action is a deviation from the standard of practice.

45. Cementing a post into a root with no apical seal and through the entire length of the root into the periapical tissue is a deviation from the standard of practice.

46. Wisch's tooth #5 subsequently developed recurrent infections. Respondent failed to appreciate the significance of these infections, failed to make a careful diagnosis, failed to inform the patient Wisch, and failed to take appropriate remedial action. All are violations of the standard of practice.

47. A radiograph taken on 12/14/99 shows the post protruding through the root end of tooth #5 and a radiolucent area around the end of the root and the protruding post.

48. Despite the above, Respondent cemented a fixed bridge abutment crown permanently onto Wisch's tooth #5. This is a deviation from the standard of practice.

50. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

COUNT FIVE / KRATKY COMPLAINT

51. Paragraphs 1 through 3 above are re-alleged.

52. On or about 11/16/98 Hilary Kratky became a patient of Respondent. During the course of treatment a billing dispute arose and Respondent ceased to provide treatment.

53. On or about 9/24/99 patient called and reported being in pain and not having heard from Respondent. On 10/05/99 Patient called and reported she saw another dentist who re-cemented her bridge.

54. On 12/9/99 patient called and still had not heard from Respondent. On or about 12/21/99 Respondent's records indicate he instructed patient be called. The patient was informed that Respondent would be "very happy to see her to finish her work when she pays her bill".

55. Refusal by a dentist to complete treatment begun, or to help arrange for completion of the treatment by another dentist constitute abandonment of a patient, whether or not the patient had completely paid for the treatment. This is in violation of 26 V.S.A. §809(a)(1).

COUNT SIX / SONNEBORN COMPLAINT

56. Paragraphs 1 through 3 above are re-alleged.

57. On or about 9/2/97 and 9/23/97 Respondent performed endodontic treatment of tooth #3 on a patient, Thomas Sonneborn.

58. On or about 11/18/97 Respondent placed an endodontic retentive post in tooth #3 for patient Sonneborn.

59. Subsequently problems developed with this tooth. Radiograms taken on 1/30/01 show a large radiolucent area surrounding the mesiobuccal root of tooth #3 and involving the other roots and the entire inter radicular area. This was not present in pre treatment and contemporary radiographs.

60. The radiographs of 1/30/01 show discontinuity of the endodontic sealing material in the mesiobuccal root, that the sealing material does not extend the full length of the root canal and that there is space between the sealing material and the wall of the canal wherever sealing material is present.

61. Failure to provide a seal is a deviation from the standard of practice.

62. Those same radiograms show a retentive post in the palatal root placed to an excessive depth, jeopardizing the apical seal. This is a deviation from the standard of practice.

63. The diameter of the post is only slightly less than the bucco-lingual thickness of the root at that level creating a significant risk of perforation or stripping fenestration of either the buccal or lingual wall of the palatal root. This risk is compounded by the fact that the palatal root of maxillary first molars is most commonly curved in the bucco-lingual plane, whereas the post-hole preparation burr is straight.

64. Respondent's radiograph of the tooth at the time of treatment, 9/22/97, shows excessive over cutting of the internal walls of the pulp chamber and the crown of that tooth, unnecessarily weakening the tooth. This is a deviation from the standard of practice.

65. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

Count Seven/Northrop

66. Paragraphs 1 through 65 are re-alleged.

67. On or about November 26, 1996 and January 16, 1997 Respondent performed endodontic treatment on tooth #3 of a patient, Diane Northrop.

68. The mesiobuccal root of tooth #3 was not filled as evidenced by radiograph. Additionally, the other roots of tooth #3 were overfilled as evidenced by the filling material extending at least 3mm beyond the apex of the roots.

69. The extrusion of filling material at the apex of the roots indicates over instrumentation of the apical portion of the roots. The excessive instrumentation of the apices of these two roots and the extent of the overfills of these roots are deviations from the standard of practice.

70. The failure to fill the third root canal or refer the patient for treatment of it is a deviation from the standard of practice.

71. The failure of the Respondent to re-examine the tooth at appropriate intervals, knowing that the one root was unfilled and therefore a potential problem, is a deviation from the standard of practice.

72. On or about March 13, 1997, Respondent placed a retentive post into Ms. Northrop's tooth #13.

73. Records indicate Respondent treated this tooth on June 18, 1999 for infection. A radiograph taken by Respondent shows an excessively long retentive post in tooth #13 perforating the root near the apex. There is also a large radiolucent area in the region of the extruding post. Subsequent radiographs taken

by another dentist clearly show the post extruding out the root into the bone and the radiolucent area in the region of the extruding post.

74. Extending the post preparation as deeply a Respondent did, into the apical region of the root, jeopardizes the endodontic seal and is a deviation from the standard of practice.

75. Respondent failed to recognize he had perforated the root and this is a deviation from the standard of practice.

76. Respondent records indicate he performed a surgical proceedure on tooth #13 in 1999. A surgical procedure would have been appropriate if it included removal of the extruded portions of the post and enough adjacent root structure to eliminate infected tissue and provide a space for a filling to seal the root end.

77. A radiograph taken on June 8, 2001 shows the root end was still present, the extruded portion of the post was still present, the radiolucent area was still present, and no retrograde filling was present. The appropriate procedures had therefore not been performed. This is a deviation from the standard of practice.

78. Respondent's records indicate his procedure included a bone graft. A bone graft would not be of any use unless the cause of infection was dealt with (the root perforation and extruding post). The performance of an inappropriate surgical procedure in this case is a deviation from the standard of practice.

79. The circumstances described above constitute unprofessional conduct pursuant to 26 V.S.A. §809(a)(14)(failure to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent dentist...).

Count Eight/Omnibus Count

80. Paragraphs 1 through 79 are re-alleged

81. In light of the above, paragraphs 1 -79 inclusive, Respondent has violated 26 V.S.A. §809(14)(in the course of practice...the failure to exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinarily skillful, careful, and prudent dentist.... engage in similar practice under the same or similar conditions...) and 3 V.S.A. §129a (a)(10).

WHEREFORE the license of Peter A. Lakatos should be revoked, suspended, or otherwise disciplined.

Dated at Montpelier, Vermont this 23rd day of January 2001.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: Robert W. Gagnon
Robert W. Gagnon
Senior Assistant Attorney General,