



Dental Practice Board *of Victoria*
Annual Report 2001 – 2002

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PRESIDENT'S COMMENTS

The Board continues to work towards improving the dental health of the public of Victoria. The transition from the requirements under the previous Act to those under the *Dental Practice Act 1999* continued during the last twelve months, with emphasis being placed on finalization of several important Codes of Practice.

The Board develops and adopts codes of practice pursuant to section 69(1) of the Dental Practice Act. The codes are not regulations, but can be considered as establishing appropriate standards for the practice of dentistry by registered persons. In the case of the Codes for the practice of dentistry by dental auxiliaries (Code 002) and by dental prosthetists (Code 001), the relevant advisory committees of the Board researched the issues and prepared a position paper for circulation. The public process included wide consultation with interested groups. The texts of the Codes can be found elsewhere in this annual report.

Of particular interest in Code 001 is a provision for dental prosthetists to be involved in the supply of overdentures to patients who have previously had dental implants placed. This demonstrates the Board's recognition that the dental prosthetist is part of an interdisciplinary system of dental care. The Board acknowledges the present lack of training by dental prosthetists in the area of dental implants, and will codify the training and patient management that will need to be undertaken in cooperation with and to the prescription of a dentist. An expected outcome will be the elevation of dental prosthetists to acknowledged providers within the dental health care team.

Central to Code 002 is a professional agreement between the dental auxiliary and a dentist. The Board has adopted a position that will respect the clinical skills and professional responsibility of the dental auxiliary, while recognising the scope of dental care able to be undertaken by this provider. The professional agreement will be individual for each auxiliary or workplace. It is this agreement that will define the skills that an auxiliary may exercise. Its aim is to provide the greatest flexibility for acquired skills to be utilized within the defined scope of practice, allowing each auxiliary to exercise professional responsibility by practising within his or her competence.

A process of review of the various interim codes transitioned from policies of the former Board, also continues. It is important to note that non-compliance with a Code may be deemed to be unprofessional conduct and dental care providers may be prosecuted if they do not comply with the codes.

I would like to thank the many individuals who have served on the advisory committees of the Board. Their time and experience has contributed greatly to the level of debate. I would also wish to acknowledge the work and commitment of the administrative staff of the Board.

The CEO, Mr Peter Gardner has made a significant contribution to the Board's development over the last twelve months. He has overseen the establishment of an online renewal of registration system. This innovation has greatly simplified a complicated administrative process. Additionally the Board has established a very informative web site which provides all members of the community with ready access to many matters in relation to the legal provision of dental health care.

I look forward to a further challenging but rewarding next twelve months to complete the statutory term of this Board.

Anthony Dickinson

MEMBERSHIP

The *Dental Practice Act 1999* specifies that the Board members must be drawn from certain categories, as follows (the names of the Board members appointed in a particular category appear in parentheses):

- One dental specialist (Dr Anthony Dickinson);
- Four dentists (Dr Deborah Cole, Dr Gerard Condon, Dr Ross Green and Dr Anthony Robertson);
- Two dental prosthetists (Mr Craig McCracken and Mr Antony Edwards);
- One dental auxiliary (Ms Julie Satur, the original occupant of this position, resigned with effect from 13 March 2002. She was replaced by Ms Pam Leong from 25 June 2002.);
- Two persons who are not dental care providers (Ms Gabrielle MacTiernan and Professor Loula Rodopoulos);
- One lawyer (Mr Jack Harty).

Dr Anthony Dickinson continued as President of the Board and Dr Gerard Condon as Deputy President.

The Act provides for three statutory committees to advise the Board. They deal with:

- dental specialists;
- dental auxiliaries; and
- dental prosthetists "and other persons qualified as dental technicians".

It was decided that each of those committees would contain two Board members (one of whom would preside) and a number of co-opted non-members appropriate to the purpose of the particular committee.

The composition of the committees was as follows (presiding Board member listed first):

Specialists Practitioners Advisory Committee

Dr Dickinson
Mr McCracken
Dr Stephen Chen
Dr Gerard Clausen
Dr Ted Crawford
Prof John Ferguson
Dr Paul Fitz-Walter
Dr Nicola Kilpatrick

Dental Auxiliaries Committee

Ms Satur (replaced, after her resignation, by Ms Leong)
Dr Robertson
Ms Catherine Osbourne
Ms Denise Galuoppo
Ms Margaret Randles-Guzzardi
Mrs Margaret McCutcheon

Dental Prosthetists Committee

Mr McCracken
Dr Green
Mr Mark Clarke
Mr Ian Gibbs
Mr John Rogan
Mr Peter Vryonis

The Board's representative on the Faculty of Medicine, Dentistry and Health Sciences of Melbourne University was Dr Ross Green.

The Board's nominee as an examiner for the Diploma of Oral Health Therapy at Melbourne University was Dr Ross King.

The Board's nominee as a member of the Australian Dental Council was Dr Gerard Condon.

The Board's delegate to the Council of Regulatory Authorities for Dental Technicians and Dental Prosthetists (CORA) was Mr Craig McCracken.

STAFF

Mr Peter Gardner (CEO)
Mrs Faye Taylor
Mrs Elizabeth Jovan
Dr Vincent Amerena (Investigative Officer)

THE REGISTER

At 30 June 2002 the total numbers registered in the various divisions and subdivisions of the register were:

Dentists	2218
Dental specialists	295
Dental prosthetists	298
Dental therapists	195
Dental hygienists	107
Dual registration (as both therapist and hygienist)	29
Students	259
TOTAL	3401

Age	Dentists (incl specialists)		Dental prosthetists		Dental Auxiliaries (Therapists & Hygienists)	
	Men	Women	Men	Women	Men	Women
<25	26	29	-	1	5	28
25-34	310	279	16	9	4	104
35-44	446	238	98	10	2	130
45-54	510	129	81	2	1	51
55-64	328	38	27	1	1	5
>64	172	8	29	-	-	-
Not known	-	-	24	-	-	-
TOTAL	1,792	721	275	23	13	318

The changing face of the dental profession is dramatically illustrated in the following graph. It shows a steady progression among dentists and dental specialists from the oldest age bracket (almost all men) to the youngest (in which women are a majority).



Age distribution of dental care providers

Age	Dentists (incl specialists)	Dental prosthetists	Dental Auxiliaries
<25	2.19%	0.34%	9.97%
25-34	23.44%	8.39%	32.63%
35-44	27.22%	36.24%	39.88%
45-54	25.43%	27.85%	15.71%
55-64	14.56%	9.40%	1.81%
>64	7.16%	9.73%	-
Not known	-	8.05%	-

A similar pattern is seen among dental prosthetists, the oldest bracket of whom are all men. (By chance the only prosthetist under the age of 25 happens to be a woman.) Statistics about dental prosthetists should be viewed with some caution because:

- at the time this report was being written, there were still some prosthetists whose dates of birth were not recorded; and
- the total numbers involved are small by comparison with those for dentists.

There is some suggestion that the sex distribution pattern seen in dentists and prosthetists is reversed among dental auxiliaries, although, again, the sample is quite small. Still, even making those allowances, the following table is of interest because it suggests that the 'average' prosthetist is older than the "average" dentist, while the "average" auxiliary is youngest of all.

While 42.6% of auxiliaries and 25.63% of dentists are younger than 35, only 8.73% of prosthetists are.

NEW CODE OF PRACTICE: DENTAL AUXILIARIES

After a comprehensive consultation process with outside organisations and a vigorous debate within the Board, the new Code of Practice for Dental Auxiliaries was finalised on 24 April 2001.

This Code introduces important reforms into the regulation of dental care in Victoria, principally by redefining the relationship between dental auxiliaries and dentists. It is characterised by realism and flexibility.

The old regulations (i.e., the system that this Code replaces) assumed the existence of a rigid hierarchy with dentists at the apex. Furthermore they were expressed in language ("...supervision, direction and control ...") that caused offence to many therapists and hygienists.

The new Code recognises the reality that dental therapists and dental hygienists are professional people in their own right. It follows that they must now accept the

responsibilities that accompany professional status and be prepared to face the same scrutiny of their standards that has previously applied to longer-established professions. It also accepts the reality that dentists, by virtue of their more extensive training and greater knowledge base, hold a special position among the dental care professions. The Code envisages a team relationship among the various types of dental care providers, with dentists taking the role of team leaders.

The core of the new Code is a professional agreement between the various practitioners in a practice or an institution. The agreement defines their relationships within the overarching parameters of the Code itself. Under this arrangement, the parties are free to construct professional relationships that are relevant to and convenient for their particular circumstances.

The text of the Code is as follows:

PREAMBLE

This Code of Practice has been developed, pursuant to s.69(1)(e) of the *Dental Practice Act 1999*, to provide a framework for the practice of dentistry by dental therapists and dental hygienists. In exercising its obligations, the Board will use this code to determine if a practitioner is acting within or outside the framework approved by the Board.

The Code will be subject to continuing review in the context of:

- evolving dental workforce needs;
- new technological developments; and
- the objectives of the Dental Practice Board.

There will be a formal review process within five years. In further developing the boundaries of this Code the Board will promote and support appropriate research into the scope of practice of dental auxiliaries, including into the utilization of dental therapists for the provision of dental health care to persons over the age of 18 years.

It is fundamental to this Code that, within the defined range of skills, dental therapists and dental hygienists

must practise only those skills for which they have been formally educated (in courses approved by the Board) and in which they are registered and competent. The Board requires registered dental care providers to possess at least the level of competence expected of a graduating final year dental auxiliary student in a course of study approved by the Board. It may take into account such matters as educational preparation, acquired skills within the parameters set out in Part 3, recency of practice and continuing professional development.

Individuals may extend their range of skills by undertaking training programs that the Board has approved.

Part 1:

This Code requires a team approach in the delivery of dental services, with a registered practising dentist or dentists adopting the role of clinical team leader(s) with overall responsibility for patient care. The dental therapist and dental hygienist work with the dentist(s) in a consultative and referral relationship to provide any or all of the following: preventive, periodontal, restorative and orthodontic dental services. A dental auxiliary may not engage in independent practice.

A dental auxiliary must only practise:

- in the employ of a registered practising dentist or dentists who shall be the team leader(s); or
- in the employ of a registered practising dentist or dentists who employ a registered practising dentist who shall be the team leader; or
- in an entity that employs a registered practising dentist or dentists who shall be the team leader(s).

Any other employment arrangement would require the specific approval of the Board.

The parties mentioned in the preceding paragraph must enter into a written agreement that outlines the professional relationships and activities that affect clinical care. That agreement must specify:

- roles and responsibilities of the auxiliary;
- roles and responsibilities of the dentist or dentists;
- competencies achieved within the areas listed in Part 3 of the Code of Practice;
- working relationships between team leader and auxiliary, including procedure and protocols for the operation of the dental team and quality assurance systems.

All parties must ensure that the written agreements are consistent with the terms and conditions of their professional indemnity insurance.

Part 2:

Dental therapists may provide dental care, as specified in Part 3, for persons up to and including 18 years of age and, on the prescription of a practising dentist, for persons between the ages of 19 and 25 years of age. There is no age restriction on the provision of orthodontic procedures by dental therapists within the parameters set out in Part 3.

Part 3:

Dental hygienists and dental therapists may perform only those tasks for which they have been formally educated (in courses approved by the Board), within the following areas:

DENTAL THERAPISTS AND DENTAL HYGIENISTS

- Oral examination including intra-oral dental radiography.
- Extra-oral dental radiography on the prescription of a dentist.
- Impression taking (for other than prosthodontic or prosthetic treatment)
- Local anaesthesia for dental procedures
- Application of therapeutic solutions to teeth, but not including 'in-surgery' bleaching of teeth
- Orthodontic procedures under the supervision of a dentist, except for
- Diagnosis and treatment planning for orthodontic treatment
- Initial fixation of bands and brackets
- Design of orthodontic appliances
- Activation and adjustment of orthodontic appliances

DENTAL THERAPISTS

- Preventive dental procedures including fissure sealants and removal of deposits from teeth;
- The restoration of coronal tooth structure damaged by or at risk from caries or damaged by trauma, including pulpotomies, but excluding indirect restorations and endodontics;
- Extraction of deciduous teeth

DENTAL HYGIENISTS

- Management of periodontal disease (excluding surgical management) within the context of an overall treatment plan undertaken by a dentist;
- Preventive dental procedures including, on the prescription of a practising dentist, fissure sealants.

NEW CODE OF PRACTICE: DENTAL PROSTHETISTS

A new Code of Practice for dental prosthetists was promulgated in June 2002.

The text of the Code is as follows:

PREAMBLE

The Board has determined to promulgate a Code of practice, pursuant to section 69(1)(e) of the *Dental Practice Act 1999*, to define the practice of dentistry by dental prosthetists.

This Code of Practice will be subject to continuing review in the context of:

- evolving dental workforce needs;
- new technological developments; and
- the objectives of the Dental Practice Board.

There will be a formal review process within five years. In the meantime the Board encourages research to examine the boundaries defined by this code.

The Board requires registered practitioners to possess the competencies set out in the Advanced Diploma in Dental Prosthetics accredited, under the Health Training Package, by the Australian National Training Authority. It is fundamental to this Code that, within the defined range of competencies, dental prosthetists must practise only those skills for which they are registered and competent. Individuals may extend their range of skills within the parameters set out in Part 2 by undertaking training programs that the Board has approved.

PART 1

This Code acknowledges that the dental prosthetist may work as an independent practitioner.

A dental prosthetist who has not completed a course of training approved by the Board in the making, fitting and repairing of partial dentures shall have a condition placed on his or her registration: "Not registered to deal directly with the public in the provision or repair of partial dentures."

PART 2

This Part sets out the areas of dentistry in which dental prosthetists may practise. It is fundamental to this Code that, within the defined range of competencies, dental prosthetists must practise only those skills for which they are registered and competent.

- 1 A dental prosthetist may work as an independent practitioner in making, fitting, supplying, repairing or taking impressions for:
 - a) removable dentures;
 - b) flexible, removable mouthguards of a type used by persons engaged in sporting activities.
- 2 Before taking any impression or fitting any removable dental appliance a dental prosthetist must take reasonable steps to ensure that the patient's mouth is fit for the purpose, and free of disease, disorder or abnormality.
- 3 Apart from the use of tissue conditioners and soft lining materials, a dental prosthetist must not adjust, modify or treat the natural dentition, bone, soft tissue or dental restorations.
- 4 A dental prosthetist may take impressions for, make, fit or supply removable implant-retained full overdentures on pre-existing implant and abutment structures in cooperation with and to the prescription of a dentist but may not:
 - a) remove or replace any implant or abutment component; or
 - b) otherwise deal directly with the public in taking impressions for, making, fitting or supplying any implant-retained prosthesis.

COMPLAINTS

The Board received 195 complaints in 2001-02 and finalised 163. In the previous year 114 had been received and 48 finalised. By any standard those figures record a substantial increase in the Board's workload and productivity.

Complaints received (by type of practitioner)

Subject of complaint	Number of complaints 2001-02	Percentage of total 2001-02	Number of complaints 2000-01	Percentage of total 2000-01
Dentist	154	79	86	75
Dental specialist	6	3	8	7
Dental prosthetist	21	11	12	11
Dental hygienist	-	-	-	-
Dental therapist	1	-	-	-
Unregistered person	7	4	7	6
Organisation	6	3	1	1
TOTAL	195		114	

What is interesting about these figures is the consistency between this year's and last year's. In both years dentists, combined with dental specialists, account for 82% of the complaints and dental prosthetists for 11%.

It is always interesting to know the sources of complaints. Who complains? About what?

Complaints received (by source)

Complaint made by	Number of complaints 2001-02	Percentage of total 2001-02	Number of complaints 2000-01	Percentage of total 2000-01
Patient	107	55	72	63
Dentist	20	10	18	16
Family of patient	13	7	1	1
Dental prosthetist	7	4	3	2.5
Dental nurse	10	5	3	2.5
Professional association	9	4	3	2.5
Statutory authority	3	1.5	8	7
Anonymous	3	1.5	3	2.5
Health insurance company	12	6	1	1
Member of the public	7	4	-	-
Initiated by Dental Practice Board	4	2	1	1
Medical practitioner	-	-	1	1
TOTAL	195		114	

Complaints received (by type)

Type of complaint	Number of complaints 2001-02	Percentage of total 2001-02	Number of complaints 2000-01	Percentage of total 2000-01
Quality of work	63	32	25	22
Advertising	35	18	17	15
Infection control	24	12	28	24
Illegal practice	17	9	7	6
Fees	11	6	6	5
Financial deception	8	4	1	1
Informed consent	8	4	9	8
Intimidation	7	3.5	1	1
Failure of communication	5	2.5	5	4
Misrepresentation	3	1.5	3	3
Overservicing	3	1.5	2	2
Fitness to practise	1	0.5	-	-
Falsifying documents	1	0.5	1	1
Breach of conditions on registration	1	0.5	-	-
Breach of confidence	1	0.5	1	1
Record-keeping	1	0.5	-	-
Finding of guilt in court proceedings	-	-	1	1
Sexual misconduct	1	0.5	1	1
Miscellaneous	5	3	6	5
TOTAL	195		114	

Some idea of the kinds of issues that prompt various types of complainant can be drawn from these tables. Where a complaint originated with a patient or a patient's family, the largest category by far (64 out of 120) was complaints about the quality of dental work. Next (21 out of 120) came complaints associated with attitude and communication (misrepresentation, informed consent issues, intimidation, failure of communication). The other two significant categories were financial matters and infection control (each 13 out of 120).

It is important to bear in mind that these were the complaints that were made, not those that were found to be justified. In the great majority of cases the Board made no adverse finding and it must be assumed that the practitioner had done no wrong. Nevertheless these figures are useful in that they illuminate the perceptions of those patients who are unhappy with the treatment they receive, and the aspects of treatment that are most likely to lead to dissatisfaction.

By contrast, when the complainant was a dentist or dental prosthetist, the dominant reason for complaining was advertising (20 cases out of 27).

The table above classifies complaints by the main issue that each one raised. However there is a degree of artificiality about the classification, since many complaints are about more than one thing. Sometimes the issue that, on investigation, turns out to be the most serious is not the one which originally prompted the complainant to contact us.

The average time that elapsed between receipt and final disposal of a complaint was 148.5 days. Last year we calculated the equivalent time as 4.3 months, which translates as 130.7 days. Any increase in the length of time taken to deal with a complaint is regrettable, but given the great increase in the number of complaints finalised this year, the total picture is quite satisfactory.

HEARINGS

The *Dental Practice Act* provides for both formal and informal hearings into the conduct of dental health care providers. Each is conducted before a panel of three or four Board members (or, in certain circumstances, a mixture of Board members and specially-selected non-members). Full details of the differences between the two processes are set out in the Act itself, which can be obtained from Information Victoria, 356 Collins Street, Melbourne (telephone 1300 366 356). In summary, the differences are:

- Informal hearings are utilised when it appears that, if there has been misconduct, it was not of a serious nature. The hearings are not open to the public and the practitioner who is under scrutiny is not entitled to legal representation. If the panel finds the practitioner to have engaged in unprofessional conduct it may determine that the practitioner be cautioned, reprimanded, required to undergo counselling, required to undertake further education or any combination of those alternatives.
- Formal hearings inquire into more serious allegations. They are normally open to the public, and the practitioner is allowed legal representation. If the panel finds against the practitioner it may impose, (as well as any or all of the determinations available to an informal hearing) any or all of: conditions on the person's registration, a fine of up to \$10,000, suspension or cancellation of the person's registration.
- If, in the course of an informal hearing, the practitioner fails to attend without good reason, or the practitioner requests a formal hearing or the panel decides that an informal hearing is inappropriate, the informal hearing will be abandoned and a formal hearing take place instead.

FORMAL HEARINGS 2001-2002

DR JOHN ZEFFERT (DENTIST)

18 July 2001

Panel: Dr Anthony Dickinson
Mr Jack Harty
Prof Loula Rodopoulos

In March 2001 Dr Zeffert pleaded guilty in the Melbourne Magistrates' Court to one charge of obtaining property by deception and one charge of false accounting. The charges related to dental work which Dr Zeffert had falsely claimed to have undertaken and for which the Transport Accident Commission had been charged. As a result, the Board conducted a formal hearing into Dr Zeffert's conduct.

At the hearing, the Panel found Dr Zeffert guilty of unprofessional conduct of a serious nature. It

1. reprimanded him;
2. imposed a fine of \$1,000;
3. required that he be counselled by an officer of the Transport Accident Commission about his professional and ethical responsibilities; and
4. suspended his registration for three months.

MR NEVILLE JAMES COLLINS (DENTAL PROSTHETIST)

5 September 2001

Panel: Dr Anthony Dickinson
Mr Antony Edwards
Mr Jack Harty
Mr Craig McCracken

It was alleged that Mr Collins had practised certain aspects of dentistry that he was not qualified or registered to perform. Specifically, it was alleged that he had fabricated partial artificial dentures for his patient Mrs G, despite not having satisfactorily completed a prescribed training course in the fabrication of partial dentures.

It was also alleged that Mr Collins had failed to implement appropriate standards of hygiene and cleanliness at his practice.

In relation to the fabrication of partial dentures the Panel found Mr Collins to have been guilty of unprofessional conduct of a serious nature. In relation to the hygiene issue it found him guilty of unprofessional conduct that was not of a serious nature.

The Panel made the following determinations:

- (a) it reprimanded Mr Collins;
- (b) it imposed a fine of \$2,500 (in doing so, it

confirmed an undertaking given by Mr Collins' counsel that Mr Collins would repay the sum of \$120 to Mrs.G);

- (c) it suspended Mr Collins' registration for three months, but stayed the suspension for a year on condition that there were no other findings against him under the *Dental Practice Act* in that period;
- (d) it cautioned Mr Collins that infection control procedures at his practice must comply with the standards promulgated by the Board;
- (e) it required Mr Collins to be counselled by staff of the Board about infection control and related matters.

DR TIMOTHY GAZELAKIS (DENTIST)

22 August 2001

Panel: Dr. A. J. Dickinson
Mr. J. Harty
Prof L. Rodopoulos

Evidence was presented that Dr. Gazelakis had been the subject of an inspection and interview by officers of the former Dental Board of Victoria in August 1998. The interview related to a complaint about non-registered persons, employed by Dr. Gazelakis, performing dentistry. As well there were several issues related to an inadequate level of infection control. Following the interview, Dr. Gazelakis met with members of the then Complaints Committee of the Dental Board and an agreement was made that:

- (a) Dr Gazelakis and a senior nurse would undertake a one-day infection control course within the next month.
- (b) All procedures at Dr Gazelakis' premises in the matter of infection control would conform with National Health & Medical Research Council guidelines entitled '*Infection control in the health care setting: Guidelines for the prevention of the transmission of infectious diseases.*'
- (c) All Schedule 4 poisons would be in a locked facility to which only Dr Gazelakis would have a key.
- (d) Administration of Schedule 4 poisons would be recorded in accordance with the *Drugs and Poisons Regulations 1981*.
- (e) An anti-retraction valve would be placed on the water line of air driven handpieces.
- (f) Unlicensed or unregistered individuals would not be allowed to take impressions or carry out intra-oral procedures for prosthetic purposes.

In the present proceedings, it was alleged that infection control standards were inadequate and that Dr Gazelakis had employed an unregistered person to practise dentistry. Counsel for Dr Gazelakis conceded that the 1998

agreement had been breached and that Dr Gazelakis was guilty of unprofessional conduct. The Panel found the unprofessional conduct to have been of a serious nature.

In considering the penalty, the Panel reflected carefully on whether the admitted breaches should result in the removal or suspension of Dr. Gazelakis's licence to practice. The Panel also gave due weight to the need for specific and general deterrence.

Evidence was presented by a clinical psychiatrist, about Dr Gazelakis' family background and her clinical of him. Her diagnosis was that Dr. Gazelakis was suffering from an anxiety-depressive neurosis, as a result of underlying personality difficulties. She admitted that such underlying personality traits are not unusual and are frequently seen in successful people, particularly those described as "workaholics". She was of the view that Dr. Gazelakis does not pose a threat to the community. The Panel considered this evidence in light of the recurrent nature of Dr Gazelakis' offences. It concluded that the psychiatric evidence, while going some way towards explaining Dr. Gazelakis 's behaviour, did not obviate his responsibility.

The Panel was not convinced that Dr. Gazelakis fully understood the scientific basis of the infection control issues that required correction. Evidence was accepted by the Panel as to the inadequacy of his records and the necessity for him to develop protocols for infection control procedures and dental records.

The Panel:

1. cautioned Dr Gazelakis that the recalcitrant nature of his behaviour, should it occur again, would leave the Board little option but to exercise sanctions that could curtail his ability to practice;
2. reprimanded Dr Gazelakis;
3. required him to undertake a further educational program in infection control, to be conducted by Dr W. Palmer, to be of at least one day in duration, and to include at least one senior chair-side assistant employee;
4. required Dr Gazelakis to work with a dental mentor, to be appointed by the Board, who would assist him in preparing a practice manual and developing protocols for administrative aspects of his dental practice;
5. imposed a fine of \$2,000;
6. suspended Dr Gazelakis' registration for two months (the suspension being stayed for 12 months provided that there was no further adverse finding against him by a Panel of the Dental Practice Board in that period.

MR GEOFFREY THORN (DENTAL PROSTHETIST)

26 September 2001

Panel: Mr Antony Edwards
Mr Victor Harcourt
Mr Craig McCracken
Dr Anthony Robertson

It was alleged that Mr Thorn had practised certain aspects of dentistry that he was not qualified or registered to perform. Specifically, it was alleged that he had fabricated partial artificial dentures for a patient, despite not having satisfactorily completed a prescribed training course in the fabrication of partial dentures.

It was also alleged that Mr Thorn had failed to implement appropriate standards of hygiene and cleanliness at his practice.

In relation to the fabrication of partial dentures the Panel found Mr Thorn to have been guilty of unprofessional conduct of a serious nature. In relation to the hygiene issue it found him guilty of unprofessional conduct that was not of a serious nature.

The Panel made the following determinations:

1. it reprimanded Mr Thorn;
2. it imposed a fine of \$2,500;
3. it suspended Mr Thorn's registration for three months, but stayed the suspension for a year on condition that there were no other findings against him under the *Dental Practice Act* in that period;
4. it cautioned Mr Thorn that infection control procedures at his practice must comply with the standards promulgated by the Board;
5. it required Mr Thorn to be counselled by staff of the Board about infection control and related matters.

DR ALBERT BLOOM (DENTIST)

8 August 2001

Panel: Dr Gerard Condon
Mr Jack Harty
Mr Craig McCracken

Evidence was presented on two main issues:

- a) an allegation that, on request from an unregistered person, Dr Bloom had signed and provided forms (bearing his provider number) for the purpose of obtaining OPG radiographs of persons who were not his patients and whom he had not seen; and
- b) an allegation that Dr Bloom had re-cemented a detached orthodontic bracket to the tooth of a patient without ascertaining the identity of the treating orthodontist or conducting any follow-up inquiries to inform the treating orthodontist about what had happened.

Both allegations were admitted.

The panel was concerned that Dr Bloom's negligent approach to the recording of patient details had created a situation where essential follow-up contacts could not be conducted. The gravity of the situation was compounded by the fact that Dr Bloom had indicated on the Radiograph Request Forms that the X-rays he had ordered were to be sent to the patient's nominated address.

The Medicare Benefit Arrangement correctly recognises that a clinical examination must precede any determination of the benefits of radiography versus the radiation risks. By ordering radiography without any clinical examination Dr Bloom apparently paid little heed to the welfare of his potential patients.

The Panel was also concerned that Dr Bloom had, albeit unwittingly, allowed himself to be misled and manipulated by an unregistered person who, probably using the lure of future employment as an inducement, attempted to secure Dr Bloom's participation in his (the unregistered person's) scheme to obtain a pool of patients.

Dr Bloom was: reprimanded; required to undergo counselling about patient records; required to attend a course, approved by the Board, in radiation safety; and cautioned that further ill-considered business dealings detrimental to patient welfare might result in higher penalties at a future hearing.

MR KENNETH MORRISS (DENTAL PROSTHETIST)

23 May and 13 June 2002

PANEL: Dr Ross Green
Mr Jack Harty
Mr Craig McCracken

The Victorian Denture Scheme ("VDS") is an arrangement, funded by the Department of Human Services, under which dentures are provided (to patients with low incomes) at a subsidised rate. Under the scheme participating dentists and dental prosthetists agree to accept the Government subsidy, plus a nominal contribution by the patient, as payment for providing the dentures.

It was alleged against Mr Morriss that, while a participating practitioner in the VDS, he charged a number of his patients a further fee in addition to the Government subsidy and the patient contribution.

Specifically, it was alleged that:

- (a) Mr Morriss provided Patient A with full upper and full lower dentures authorised under the VDS scheme but, in addition to the fees which he was entitled to receive, he charged the patient a total fee of \$450.00;

- (b) Mr Morriss provided Patient B with full upper and full lower dentures authorised under the VDS scheme but, in addition to the fees which he was entitled to receive, he charged the patient a total fee of \$430.00;
- (c) Mr Morriss provided Patient C with full upper and full lower dentures authorised under the VDS scheme but, in addition to the fees which he was entitled to receive, he charged the patient a total fee of \$430.00;
- (d) Mr Morriss provided Patient D with full upper and full lower dentures authorised under the VDS scheme but, in addition to the fees which he was entitled to receive, he charged the patient a total fee of \$455.00.

The panel found that each of the allegations had been proved and that Mr Morriss had been guilty of unprofessional conduct of a serious nature.

It was the panel's opinion that this case centred on only a few relevant issues.

The Guidelines of the Victorian Denture Scheme clearly state that patients must not be charged amounts over and above the published amount for items of care already included in the scheme. The VDS schedule includes full dentures. The Guidelines state that treating a patient and subsequently submitting a claim for payment, is taken as an agreement to adhere to program guidelines.

Mr Morriss admitted that he had an obligation to abide by the Scheme guidelines. He admitted that he had received a copy of those guidelines. He also admitted having applied in writing to be included in the participating practitioner lists for the VDS. Evidence was presented that Mr Morriss submitted claims for payment under the VDS for full dentures supplied to the four patients. He admitted that he had charged them amounts ranging from \$430 to \$455, when the guidelines stipulate a patient payment of only \$85.

The Panel did not accept the argument put on Mr Morriss' behalf that spending additional time on a case, using special trays to take secondary impressions, or using "anatomical" articulators constitute additional denture services under the meaning of that term in the Participating Practitioner Guidelines. The panel was of the opinion that the guidelines are sufficiently clear to allow practitioners to have a clear understanding of the concept of additional denture services in this context. This is particularly so as the examples of allowable additional services listed in the guidelines are all physically identifiable items. No evidence was presented that items such as secondary impressions, extra time taken, the use of "anatomical" articulators, or a choice of teeth, are

services which are normally (or indeed ever) separately itemised and billed to or on behalf of denture patients, in public or private practice.

The panel found Mr Morriss' conduct in using the VDS to promote himself to pensioner groups, when, by his own admission, he was not prepared to provide dentures under the rules of the scheme, to be of particular concern.

The evidence given by Patients C and D (a married couple), that the money they paid to Mr Morriss was their "emergency fund", and by Patient B that he had to borrow money to pay Mr Morriss, highlights the extremely limited means of the patients involved in this case. These are the people whom the VDS was intended to help, and additional payments of this magnitude place a heavy financial burden on them.

The panel reprimanded Mr Morriss and directed that he:

- 1) be not be permitted to perform clinical procedures for patients under the Victorian Denture Scheme until July 1st 2004; and
- 2) be fined the amount of \$4000.

DR LEONID EXLER (Dentist)

10-11 May, 16-17 August, 23 August and 10 September 2001

Panel: Dr Ross Green
Mr Jack Harty
Ms Julie Satur

This lengthy hearing covered a number of matters which may, for convenience, be grouped under the following headings:

1. Advertising issues
2. Informed consent issues
3. Infection control and related issues
4. Practice systems for infection control, staff training and records management.

1 Advertising Issues.

The panel found that:

- a) Dr Exler had breached regulation 402 of the *Dentists Regulations 1992*, and Section 64 of the *Dental Practice Act 1999*, by publishing various advertising material. Certain of that advertising material was published before June 30 1999, when Regulation 406 was in force. The remainder of the advertising material was published after June 30 1999, when the *Dental Practice Act 1999* was in operation. The advertising material published before June 30 1999

was in breach of Regulation 406, and the advertising material published after that date was in breach of Section 64 of the *Dental Practice Act 1999*.

- b) Dr Exler had breached those provisions by placing advertisements in the 2000 and 2001 Yellow Pages telephone directory, creating the false, misleading and deceptive impression that :
- (i) He had a dental practice at a particular location (576-578 South Road, Moorabbin) (2000 Yellow Pages), whereas in truth and in fact no such dental practice existed; and
 - (ii) He had a dental practice at a particular location (267 Clayton Road, Clayton) (2001 Yellow Pages), whereas in truth and in fact no such dental practice existed.
- c) Dr Exler had breached Regulation 406 by stating in his application form for renewal of his registration as a dentist in Victoria (dated December 14 1999) that his fifth practice address was 576-578 South Road, Moorabbin; he had breached Section 64 by stating in his application for renewal of his registration as a dentist in Victoria (dated December 23 2000) that his fifth practice address was 267 Clayton Road, Clayton;
- d) Those statements were false, misleading and deceptive because, in truth and in fact, Dr Exler did not have a dental practice at either of those addresses (Moorabbin or Clayton).
- e) Dr Exler had erected large signage at his Balwyn premises reading "Dentist open 7 days 9.00 am to 9.00 pm"; These statements were false misleading and deceptive because, in truth and in fact, his Balwyn practice was not open seven days per week from 9.00am to 9.00pm.

Pursuant to S.25 (1) of the *Dentists Act 1972*, the Panel found that Dr Exler had been guilty of professional misconduct.

Pursuant to S.47 (1) of the *Dental Practice Act 1999*, the panel found that Dr Exler had engaged in unprofessional conduct of a serious nature.

The breaches in relation to the Yellow Pages advertising were clear. One of the street addresses advertised was a vacant block of land, and clearly not a dental practice. The other was a medical practice. The panel found the evidence from the medical practitioner concerned regarding the Moorabbin address (that Dr Exler had never seen patients at the premises), and the photographic and written evidence from the investigator, convincing. Dr Exler admits that no practice has ever or does now exist in Clayton. Dr Exler may indeed intend to eventually set up a practice in these areas; however he has an obligation under the legislation to ensure his advertising is not false, misleading or deceptive.

The panel viewed the breaches in relation to the Yellow Pages as serious. There was potential for patients to be inconvenienced, particularly when seeking emergency or after hours treatment, by being given the erroneous impression that dental practices available for emergency care were operating at these addresses, when in fact they were not.

Dr Exler must have been well aware of the importance of his advertising being factual, since he had previously had conditions placed on his practice, following an earlier Board Inquiry. These conditions required him to have prior approval from the Board before any Yellow Pages advertising was published.

The panel was not impressed by Dr Exler's explanation of a lack of understanding of the Board's position, and of a period of confusion during which "the advertisements for my various clinics made their way into Yellow Pages Directory". The communications on behalf of the Board were clear, and the condition placed on his practice in 1997 certainly was. Even if the condition had not been renewed and was no longer in force, Dr Exler should have been more aware than most dentists of the need for care with his advertising. Indeed his submission of proposed advertising to the Board for approval would indicate he did so understand the seriousness of the issue.

The panel has not made a finding in relation to the advertising of a 24 hour emergency service at all advertised locations, when in fact the practices are not physically open and staffed 24 hours per day. The panel is of the belief that the public would not expect facilities advertising a 24 hour service to have a dentist physically present all the time, but that the availability of treatment, with dentists contactable on mobile telephone or pagers, as seems to exist in this case, is a reasonable expectation.

The breach in relation to Dr Exler's applications for renewal of registration in 1999 and 2000 are admitted in his affidavit, and confirmed by the documentary evidence. His claim that he did not intend to mislead is not relevant, since intent is not a necessary condition for a breach.

The signage at the Balwyn practice was judged to be false, misleading and deceptive in that a member of the public might reasonably expect a dental practice advertising specific hours such as 9.00AM to 9.00PM to be physically open during that period, and to have a dentist present. These are hours when many similar medical services would operate. Evidence was given that the Balwyn practice was not actually open and staffed during the hours advertised. The panel judged the matter to be serious in view of the potential for inconvenience or actual harm, if a patient in need of emergency treatment travelled to the practice expecting treatment, only to find it

closed. The panel has also considered Dr Exler's previous exposure to advice from the Board in relation to the need for his advertising to be accurate.

The panel has made no finding in relation to the allegation that Dr Exler breached a July 1997 condition imposed on his practice, requiring him to seek prior approval from the Board for any proposed Yellow Pages advertising. Whilst he clearly has not strictly complied with the condition, the panel had some doubt about the quality of communication between Dr Exler, the Registrar, and the Board. The panel also had doubts about the requirement for such conditions to be reviewed annually. The lack of an adverse finding in this situation should not be construed as condoning Dr Exler's lack of compliance with a condition imposed by the Board. The panel was not reasonably satisfied on the balance of the evidence presented.

2 Informed Consent Issues - Ms R

The panel found that

- (a) During or about December 2000, Dr Exler provided dental treatment to a patient named R, without obtaining her prior consent, fully and appropriately informed, to that dental treatment being performed;
- (b) Dr Exler failed to provide R with all necessary and appropriate information about the benefits, risks and possible complications of the dental treatment proposed.

(in which respects he had engaged in unprofessional conduct of a serious nature)

and

- (c) Dr Exler had misled Ms R about the procedure which he would follow in regard to payment of his accounts, and about his relationship with HBA.

In this respect the panel found that he had engaged in unprofessional conduct which was not of a serious nature.

The primary evidence available to the panel on this issue was the statement by Ms R and the affidavit of Dr Exler. Ms R stated that she was given insufficient information on the proposed treatment to allow her to make an informed decision. She further claims she was not in a fit state, at the time, to make a rational decision. Dr Exler, on the other hand, states that some explanation of the rationale for the procedure, and its alternative (extraction), was given, and that the patient was not in an unfit emotional state at the time.

The panel found Ms R to be a credible witness. Defence counsel alleged that her complaint was motivated by

financial motives; whether this is true or not, the factors influencing the making of the complaint are irrelevant to the substance of the matter. Ms R's evidence was tested at hearing under fairly rigorous cross-examination.

Dr Exler, on the other hand, gave evidence via an affidavit, and chose not to give evidence in person. His evidence in this matter was therefore not tested. In other areas of this case, the panel has found Dr Exler's evidence to be questionable. It was contradicted by the evidence of former staff members, former associate dentists, and others.

There was no evidence presented to support Dr Exler's version of the events. There are no notes on the treatment card detailing any information given to the patient on the rationale for the treatment, its benefits, risks, possible complications and any alternatives. The evidence indicates that there was a staff member present during the treatment. She did not appear to give evidence. In cases of dispute between dentists and patients over information provided, notes made on the treatment record are an important source of information. The panel is of the view that if Dr Exler had provided the information to Ms R, he should have noted it on the treatment card.

The question of Ms R's history of psychiatric treatment was raised by defence counsel. It is noted that she had disclosed the history, and her anti-depressant medication, on the medical history form she completed for Dr Exler's practice. The panel is of the opinion that, once informed of Ms R's history of anxiety and depression, Dr Exler had an obligation to take greater than normal care in providing her information about proposed treatment, allowing her time to assimilate the information, and ensuring she was in a fit state medically and emotionally to give informed consent.

Dental appointments involving emergency root canal treatment are often difficult. The patient is often in severe pain, and treatment needs to be performed immediately to alleviate the pain; however root canal treatment is complex, invasive and expensive, and a considerable amount of information needs to be conveyed to the patient in order for them to make a properly informed decision. These problems are often complicated by the dentist's lack of time, as patients such as these are often 'squeezed in' as emergencies. Dr Exler's task on the day in question was certainly not easy. The panel has formed the view, however, that his handling of the communication issues with Ms R fell substantially short of the standard expected of a registered dentist in Victoria, and that the offence is more serious because of the psychiatric history and current medication voluntarily disclosed by the patient.

3 Infection Control and Related Issues

The panel found that Dr Exler, being a dentist bound initially by the *Dentists Act 1972* and later by the *Dental Practice Act 1999*, and by the regulations promulgated under the *Dentists Act 1972*, and maintaining premises in which he practised at Balwyn, Brighton, Broadmeadows and Doncaster ("the premises") was in breach of both paragraphs (a) and (b) of the *Dentists Regulations 1992*, promulgated under the *Dentists Act 1972*;

Regulation 401 (2) required dentists to ensure that:

- "(a) the premises in which he or she practises are kept in as clean and hygienic a state as practicable to prevent the spread of infectious disease; and
- (b) in attending a patient, he or she takes such steps as are practicable to prevent or contain the spread of infectious disease."

Those provisions of Regulation 401 had been adopted by the Dental Practice Board (under the *Dental Practice Act 1999*) as an Interim Code of Practice.

In particular Dr Exler had failed to comply with the guidelines for the prevention of transmission of infectious diseases published by the National Health and Medical Research Council and the Australian National Council on AIDS during April 1996 and entitled *Infection Control in the Health Care Setting*.

Pursuant to S.25 of the *Dentists Act, 1972* the panel found that Dr Exler had been guilty of professional misconduct.

Pursuant to S.47(1) of the *Dental Practice Act 1999* the panel found that Dr Exler had engaged in unprofessional conduct of a serious nature.

The panel also found that Dr Exler had failed to store, secure and routinely record administration of Schedule 4 Poisons (as specified in Schedule 4 to the *Drugs, Poisons and Controlled Substances Act 1981* and the *Drugs, Poisons and Controlled Substances Regulations 1995*) at his practice premises. On this point, pursuant to S.47(1) of the *Dental Practice Act 1999*, the panel found that Dr Exler had been guilty of unprofessional conduct which was not of a serious nature.

A considerable amount of written, photographic and verbal evidence was presented by the Board's Investigative officer, Dr Amerena. The panel found the evidence clear and convincing. Dr Amerena was unchallenged as an acknowledged national expert on infection control in dentistry. There was also evidence that registered persons had been given clear information by the current Board and its predecessor, on the required standards in this area. The NH&MRC publication entitled *Infection Control in the Health Care Setting : Guidelines*

for the prevention of transmission of infectious diseases, and the Australian Standard AS4187 have been quoted on numerous occasions to registered persons as the required standard. The departures from the accepted standard were numerous and wide - ranging. A few were minor and technical; however most of the breaches alleged related to activity or omissions which would not be expected of registered dentists practicing to a reasonable standard. Several, such as the lack of documented validation of the autoclave, and the pre-loading of local anaesthetic syringes, were potentially extremely dangerous. Of most concern to the Panel was the apparent lack of any conscientious attempt by Dr Exler to seek to achieve optimum standards of safety in infection control. In fact the converse appears to be the case: he has sought throughout this case to deny his responsibility for infection control matters in his practices.

Dr Exler admitted in his evidence that he regularly and routinely practised dentistry at all of the practice locations mentioned in the charges, and cannot, therefore, avoid responsibility for infection control issues.

Evidence was presented in the form of photographs, affidavits, and the testimony of witnesses that many of the matters mentioned in the charges have since been resolved. Whilst this is pleasing, it does not alter the facts at the time of the investigation. Dr Bill Palmer, an acknowledged expert in infection control, who regularly performs practice audits and training in infection control, had attended the Balwyn practice, and had given the opinion that "the potential for cross infection was not assessed as high". His report did, however, list a number of infection control shortfalls. This is deemed significant by the panel, as his visit occurred as late as May 2001, well after the improvements claimed by Dr Exler and his witnesses. At the date of his giving evidence, Dr Palmer had still not visited any of the other Exler practices. During his visit to Balwyn, neither Dr Exler nor any other dentist was present.

Evidence was presented of local anaesthetic, a Schedule 4 substance, stored in unlocked storage areas. The law clearly requires that such drugs be kept in locked storage when there is no registered person on the premises. Evidence was also presented that all registered persons have been informed of these requirements.

4 Practice systems for infection control, staff training, and records management.

The panel found that:

- (a) Dr Exler had not set up any adequate or appropriate systems or programs to educate, train and instruct his staff on infection control principles, policies and procedures relevant to his

practice, nor had he set in place a formal orientation program for new staff members (and particularly newly engaged dental nurses);

- (b) He had not set up any adequate or appropriate systems to instruct newly engaged/employed dentists on infection control principles, policies and procedures relevant to your practice.

On these points the panel found pursuant to S.25 of the *Dentists Act 1972*, that Dr Exler had been guilty of professional misconduct, and pursuant to S.47(1) of the *Dental Practice Act 1999* that he had engaged in unprofessional conduct of a serious nature.

The panel found that Dr Exler had not set up adequate and appropriate systems at his various practice premises to ensure that patient dental records (including radiographs) were safely and securely retained, and not regularly lost or misplaced. On this point the panel found, pursuant to S.47(1) of the *Dental Practice Act 1999* that he had been guilty of unprofessional conduct which was not of a serious nature.

The NH&MRC document, *Infection Control in the Health Care Setting: Guidelines for the prevention of transmission of infectious diseases*, clearly requires that managers of health care facilities set up appropriate systems or programs to educate and instruct staff on infection control principles, policies and procedures. As stated earlier, plentiful notice has been provided to registered persons of the status of this document.

The panel was required to decide as to whether adequate and appropriate systems or programs were in place in the Exler practices. It was also necessary to determine whether Dr Exler was the person responsible for the existence or lack of said systems or programs.

The Panel heard much evidence describing a lack of any such systematic approach to infection control and staff training in the Exler practices at the time of the investigation. The impression gained by the panel was that few if any nursing staff in the practices had formal qualifications. Evidence was given of high rates of staff turnover. None of the staff had attended an infection control course during their employment with Dr Exler. There was no evidence of any formal induction or orientation procedure for new staff. The panel gained the impression that staff were motivated in their attitude to infection control primarily by their personal ethical principles, rather than by a framework set by management. One current dental nurse had used her own initiative to obtain information from an autoclave manufacturer on operation of the autoclave. This current dental nurse was aware of the NH&MRC *Guidelines* and AS4187. She still had not attended a formal course on

infection control, despite being the responsible dental nurse at the Broadmeadows practice. Former staff gave evidence that they had never seen the NH&MRC *Guidelines* or AS4187.

The Panel found the evidence of a lack of a systematic and planned approach to infection control, staff induction and training, at the time of the investigation, to be compelling.

There is no doubt that the Act requires individual registered persons to take responsibility for compliance with its requirements, specifically, in this case, in the area of infection control, as it relates to their own practising activities.

As to the question of Dr Exler's responsibility, much evidence was presented by the defence in support of the proposition that the individual dentists working in the practices were responsible, and not Dr Exler. This evidence included documents, purporting to be real estate leases, which, it was claimed, made the dentists working in the practices independent contractors. It may or may not be the case that, from the point of view of taxation or employment law, the dentists were in fact not employees but independent contractors. That judgement is outside the competence of this panel; however the panel has formed the view that these arrangements, described by Dr Exler's accountant as being for the purposes of asset protection and taxation structuring, have no bearing on the allocation of responsibility for the practice systems for infection control, staff orientation, and training.

Dr C, the most senior of Dr Exler's former associate or employee dentists, accepted responsibility for alleged breaches of infection control protocol in his own hands. But when questioned as to who had the power to appoint or terminate staff, order supplies or equipment, direct staff about general matters to do with the practice, or set up general infection control practices and protocols, he answered: "Dr Exler".

The panel gained the clear impression from all former or present staff who appeared as witnesses that, regardless of the corporate or contractual structures in place, only Dr Exler had the power to make decisions in areas such as general practice procedures, infection control protocols, equipment, staffing and training.

Dr Exler's counsel stated, in part:

"but in so far as there is an owner who also functions as a service provider and whose name is bruited as that of the coordinated practices, he's got responsibilities in that regard. Namely to integrate, to coordinate and to provide facilities within which the care can be properly dispensed to patients."

Considerable evidence was submitted by the defence on arrangements which were alleged to have been put in

place to improve infection control and management within the various practices, since the original investigation. As stated earlier, if this were the case it would be encouraging. The matters being heard, however, related to behaviour at the time of the investigation, and the panel had to make decisions based on the evidence at the time of the investigation. Changes to the practice systems, later put in place, may be relevant to the severity of any penalty. Dr M, currently employed or engaged in the practices, was held up in evidence as a dentist giving advice on infection control systems in the practices. Dr M did not, when giving evidence, claim to be an expert in infection control. Cross - examination disclosed deficiencies in Dr M's knowledge.

The panel noted that, even up to the time of the end of the hearing, no structured arrangements had been put in place, for the training of staff in infection control. Dr Bill Palmer gave evidence that he had been retained to visit and audit the Balwyn practice on its infection control systems. On the day he attended the practice, no dentist was present to participate in the process, and the nurse he had been working with was changed mid-way through the procedure. Dr Palmer gave evidence that there had been discussion regarding his looking at the other practices, but that no arrangements had so far been made.

Dr Palmer also gave evidence that Dr Exler had arrived at one of his (Dr Palmer's) infection control education seminars, without being registered, near the end of the day, and had approached him with a number of questions and statements on infection control. Dr Palmer and his education programs for infection control are extremely well known and widely advertised to the dental profession in Victoria. Education days, half days and evenings are held frequently and at a range of times, and are thus very accessible. The panel therefore viewed as serious the lack of any coherent attempt by Dr Exler to make any arrangements to obtain expert assistance to develop systems for, and to train staff in, infection control.

Evidence was given of problems within and between the various practices with patients' records, including radiographs. Examples were given of radiographs having to be re-taken when the original films went missing. There was clearly evidence that the records management practices fell below the required standard; however the panel did not believe the evidence to be strong enough to justify a finding of unprofessional conduct of a serious nature.

In summary:

1. Under the *Dentists Act 1972*, Dr Exler was found guilty of 3 charges of professional misconduct in relation to

- advertising which was false, misleading and deceptive
- inadequate infection control practices
- matters relating to practice systems for infection control, staff training and records management.

Dr Exler was reprimanded for each of these offences.

2. Under the *Dental Practice Act 1999*, Dr Exler was found guilty of:

- (a) Four charges of unprofessional conduct of a serious nature in relation to
 - advertising which was false, misleading and deceptive
 - lack of adequate consent for treatment
 - inadequate infection control practices
 - matters relating to practice systems for infection control, staff training and records management.
- (b) Three charges of unprofessional conduct not of a serious nature in relation to
 - information provided regarding health fund rebates
 - storage of Schedule 4 Poisons and dental records plus
 - inadequate infection control practices.

In relation to the charges of 2(a) and 2(b) the Board imposed the following penalties.

- A reprimand;
- A caution;
- Fines totalling \$34,000;
- Suspension of registration for three months;
- Conditions relating to training in infection control for himself and staff, infection control procedures at all practices and employment of staff trained in infection control procedures plus regular and random audit of all practices. These conditions apply until 14th April 2004 unless the Board determines otherwise.

INFORMAL HEARINGS 2001-2002

Dr J (Dentist)

The Board received a complaint from a patient, Ms O, that Dr J had displayed rudeness and over-familiarity towards her in the surgery. She also alleged that treatment options and procedures had not been explained to her adequately.

The Board's attempts to investigate this matter were frustrated by the fact that Dr J repeatedly failed to reply to correspondence about it.

The panel found that Dr J had engaged in unprofessional conduct, which was not of a serious nature, in that

1. while treating Ms O he inappropriately took her by the hand; and
2. during treatment he physically turned her head to face him, and instructed her to look at him.

A charge that Dr J had made inappropriate remarks of a sexual nature was not proved.

The panel

- a. Reprimanded Dr J; and
- b. Required him to enter into an undertaking that he would attend counselling with an officer, or officers of the Board, with respect to the issues of informed consent, client-patient relationships and record keeping.

Due to conflicting evidence from Ms O on the one hand and from Dr J and his nurse on the other, the panel was not satisfied that Dr J had made inappropriate remarks of a sexual nature. Legal counsel advising Dr J accepted full responsibility for his failure to respond to the Board's communications, and while it is the individual's responsibility to ensure that his legal advisors respond appropriately to the Board's requests, in this case his failure to do so does not constitute unprofessional conduct.

In the course of the proceedings it became apparent to the panel that the most significant issue in this case was that of informed consent. Ms O at times felt confused, pressured, distressed and humiliated by the experience. Dr J failed to inform the patient of all her options, and she felt him to be both uncommunicative and angry. Dr J did express some concern and remorse for the distress he had unwittingly caused, and the Board took his attitude into account. It was felt that if Dr J agreed to give a written undertaking to the Board that he would attend counselling on various issues around informed consent and record keeping, the Board would not need to hold an additional hearing into these issues. Dr J willingly agreed to this proposal.

Ms E (Dental prosthetist)

It was alleged against Ms E that she had not made a written dental record for a patient, Ms L. It was further alleged that when a complication occurred (namely that, while an impression was being taken for repair of a denture, Ms L's bridge was dislodged) Ms E cooperated with another dental prosthetist who, by re-cementing the bridge, practised dentistry outside the scope of practice of dental prosthetists. (See the case of Mr K, below).

The panel found that Ms E had engaged in unprofessional conduct that was not of a serious nature. It:

- reprimanded her in relation to her failure to keep a written dental record;
- cautioned her about her involvement in re-cementing the bridge; and
- required her to undergo counselling about record-keeping.

Ms E confirmed the allegation about her failure to keep a written dental record. She said that it had been her normal practice to not write records for repair and "one off" patients. Since the allegation had been made known to her, she had begun keeping written records of all patients.

Ms E conceded that she had assisted Mr K to repair Ms L's bridge, in an effort to do what they thought was best for the patient in the circumstances. She said that she had been quite distressed when the bridge was dislodged. It was her belief that the temporary replacement of the bridge was the most appropriate care in all the circumstances. She thought it would have been difficult to gain access to a dentist (these events occurred on a Friday afternoon). She admitted that she had not attempted to contact a dentist, but insisted that she had urged Ms L to contact her dentist as soon as possible.

Ms E freely made admissions and was extremely contrite. She had modified her behaviour and was already seeking additional assistance. The panel viewed positively her desire to improve her record-keeping and to refrain from providing dental care outside the scope of a prosthetist's practice.

The risk to the public was judged to be low. The panel was of the view that the counselling process would ensure an improvement in Ms E's record-keeping.

Mr K (Dental prosthetist)

Mr K is the other dental prosthetist to whom reference was made in the case of Ms E (see above). He was also Ms E's employer

The panel

- reprimanded Mr K in relation to:
 - the failure to make a written dental record and to ensure that his employee made a written record; and
 - providing treatment outside the scope of practice for dental prosthetists (specifically, his action of re-cementing the bridge for Ms L); and
 - determined that Mr K undergo counselling with respect to dental record keeping.

Mr K confirmed the allegation in relation to his failure to ensure that his employee, Ms E, wrote a dental record for

Ms L. He also confirmed that it had been normal practice to not write dental records for repair and other one-off patients. He did not record any details in relation to the emergency care he provided in re-cementing the bridge. Since the allegation was made known to him, all patients now have patient records drawn up.

Mr K explained that he had re-cemented the bridge with a composite resin material in an effort to do what he and Ms E thought best for the patient in the circumstances (i.e. the temporary replacement of the bridge on a Friday afternoon, when they thought access to a dentist would be difficult). He indicated that both he and Ms E had been quite distressed when the bridge was dislodged in the impression. Mr K admitted that he did not attempt to contact a dentist but he knew that Ms E had recommended on several occasions that Ms K contact her dentist as soon as possible. He had explained to the patient that what he had done was a temporary treatment that would hold the bridge in place until she saw the dentist. He did not foresee that the dentist would have trouble removing the bridge.

Mr K freely made admissions and was extremely contrite. He had modified his behaviour and was already seeking additional assistance. The panel viewed positively his desire to improve the record keeping and to refrain from providing dentistry outside the scope of a prosthetist's practice.

The risk to the public was judged to be low. The panel was of the view that the process of counselling would ensure an improvement in record keeping.

Mr Z (Dental prosthetist)

It was alleged that Mr Z had:

- a) published advertisements claiming that he practised at addresses where he did not, in fact, practise;
- b) published advertisements that were misleading in their use of the terms "specialise" and "special discounts";
- c) published advertisements that were so worded as to create an unreasonable expectation of beneficial treatment; and
- d) failed to comply with the Board's infection control standards.

The panel found that, as regards allegations a), c) and d) Mr Z had been guilty of unprofessional conduct that was not of a serious nature. As regards allegation b) it did not make a finding against Mr Z, but warned him about the importance of ensuring that words like "specialise" were not used in such a way as to mislead the public.

The panel reprimanded Mr Z for his behaviour which, in the panel's view, had reflected his lack of understanding

of his professional responsibilities. The panel believed that his desire for commercial success had taken precedence over those responsibilities. In particular, the panel emphasised the necessity for dental care providers to comply with the infection control standards promulgated by the Board.

The panel cautioned Mr Z that if the same issues were to arise in his practice again the Board might choose to deal with them by a formal hearing.

The panel directed Mr Z to undertake an infection control course approved by the Board of at least one day's duration.

The panel directed Mr Z to obtain copies of the National Health and Medical Research Council document Infection Control in the health care setting and the Australian and New Zealand Standard AS/NZ 4815. The panel required him to give an undertaking that he would read and comprehend the matters relevant to his practice that were contained in those documents.

The panel directed Mr Z to submit to the Board for approval, within one month of the hearing, revised protocols for the clinical dental services he provides.

Dr Y (Dentist)

The panel found that Dr Y had engaged in unprofessional conduct which was not of a serious nature by practising while unregistered.

The panel cautioned and reprimanded him.

The Panel had clear evidence that Dr Y was not registered for the period of time, April 1st to May 31st (inclusive). Records provided by two private health insurers indicated that he had practised within this period of time. He substantially admitted the facts as presented, but offered in mitigation that he had initially been trying to confirm details of his professional indemnity insurance, prior to a severe back injury which he suffered on February 26th, after which he had been hospitalised for a period of 8 days, and then unwell for several weeks thereafter. This had distracted him from attending to the various communications from the Board, and from pursuing the issue of his professional indemnity insurance details with his insurer.

The Panel has a number of concerns about Dr Y's conduct, both with his dealings with the Board, and also with the implications for his patients arising from his conduct.

1. His ignoring of repeated correspondence from the Board, was at the very least irresponsible.
2. His explanations to officers of the Board for his actions were misleading, in that he overstated his

- period of hospitalization and also incorrectly stated the period that he had been absent from work.
3. His failure to confirm the details of his professional indemnity insurance meant that the Board was unable to register him, which in turn placed his patients at some potential risk.
 4. His unregistered status meant that private health insurers in some cases declined to provide rebates to his patients, causing the latter some financial disadvantage.

The panel stressed to Dr Y the importance of registration for professionals in that it provides a measure of protection for the public. Any lapse in attending to professional responsibilities is to be deplored, but even more so in this case given the extended period over which his conduct occurred. However, the panel accepted that there were some mitigating circumstances.

WHISTLEBLOWERS PROTECTION ACT 2001

No disclosures under this legislation were made to the Dental Practice Board in 2001-02

CLAIMS FOR DAMAGES; ALLEGATIONS OF NEGLIGENCE

Under s.20 of the *Dental Practice Act*, practitioners are required to notify the Board if they are ordered by a court or if they otherwise agree to pay damages or other compensation for alleged negligence. This obligation arises if the amount involved is over a certain limit (fixed by the Board at \$10,000).

In 2001-02 the Board received 15 notifications of this kind (25 in the previous year). The amount of detail provided varied greatly between notifications (for instance some notifiers revealed the amount of settlement while in other cases all details were suppressed by the court). No notifications were received about dental prosthetists, dental hygienists or dental therapists. There were 10 about general dentists, 4 about dental specialists and 1 about a former dentist who is no longer registered. No individual was the subject of more than one report.

STATUTORY COMMITTEES

The Board has three statutory committees, established under s.82(1) of the *Dental Practice Act 1999*.

SPECIALIST PRACTITIONERS ADVISORY COMMITTEE

The role of this Committee is to provide expert advice on dental care matters relating to the special branches of dentistry recognised by the Board and specified in the dental specialist sub-division of the register.

The Committee must be chaired by a member of the Board who is a registered specialist. In other respects the composition of the Committee is not prescribed, and was determined by the Board. It chose to include representatives from the major specialist designations and one non-specialist member of the Board in addition to the Chairman. Up to June 30, 2002, the members of this Committee were the following:

Dr Gerard Clausen (Prosthodontist)	(5 attendances)
Dr Edward Crawford (Orthodontist)	(6 attendances)
Dr Stephen Chen (Periodontist)	(4 attendances)
Dr Anthony Dickinson (Board member)	(6 attendances)
Professor John Ferguson (Oral & Maxillofacial Surgeon)	(4 attendances)
Dr Paul Fitz-Walter (Endodontist)	(4 attendances)
Dr Nicola Kilpatrick (Paediatric Dentist)	(3 attendances)
Mr Craig McCracken (Board member)	(5 attendances)

Beyond assessing applications for specialist registration (resulting in a recommendation to the Board), the major focus of the Committee has been the development of:

- a list of designated specialist titles; and
- the requirements for registration as a specialist.

The registrable specialist titles are no longer prescribed in the Act as they were in Regulation under the former *Dentist Act 1972*. At the promulgation of the *Dental Practice Act* (on July 1, 2000) the Board accepted, as a transitional arrangement, the list of specialties that had existed under the former Act.

The Committee has worked diligently in debating the issues surrounding the designation of specialties, and expects that a recommendation will soon be put to the Board to be finalized.

Similarly, the Board also carried forward, as an interim measure, the former requirements that an applicant needed to satisfy to be registered as a specialist. As a result, the Board currently accepts a Masters Degree from an Australasian University or its equivalent for all

speciality designations except Oral and Maxillofacial Surgery (OMS). In the case of the latter, an applicant is required to satisfy the Board that they of his or her eligibility for the award of a Fellowship of the Royal Australasian College of Surgeons (FRACDS) in the Special Stream of OMS. This is consistent with the Commonwealth Health Insurance Commission's ruling to recognise Oral and Maxillofacial Surgeons (for the purpose of having their patients benefit from the Medicare Schedule) who have an FRACDS (OMS).

The Committee identified inconsistencies in the current requirements. The various specialties have considerable differences in the training required and thus in the training programs. University based Master's programs offer an academic education, many having included a clinical training component. For a clinical discipline such as dentistry, the clinical training program inside the academic training may not be adequate to provide the depth and breadth of competence that the public would expect of a specialist practitioner. Oral and Maxillofacial surgery, for example, offers a separate surgical training program that is conducted parallel to the Master's Degree program and in conjunction with the completion of a MBBS.

The Committee has consulted widely on these issues, and the responses have been extremely helpful. I acknowledge and greatly appreciate the contributions of all Committee members. The expertise they have brought to the Committee has allowed a significant depth of understanding to be reached.

DENTAL AUXILIARIES ADVISORY COMMITTEE

The role of this committee is to provide the Board with expert advice on dental care to be provided by registered dental auxiliaries and other persons employed as dental assistants.

Membership of the committee was:

Ms Denise Galuoppo	(3 attendances)
Ms Pam Leong (Board member) (from 25 June 2002)	
Ms Catherine Osborne	(2 attendances)
Ms Margaret McCutcheon	(3 attendances)
Dr Anthony Robertson	(3 attendances)
Ms Margaret Randles-Guzzardi	(3 attendances)
Ms Julie Satur (Board member) (resigned 13 March 2002)	(2 attendances)

Another Board member, Dr Deborah Cole, also attended one meeting of this committee.

The highlight of the year for the Dental Auxiliary Subcommittee (DAAC) was undoubtedly the promulgation of the *Code of Practice: Practice of dentistry by dental hygienists and dental therapists* on the 24th April 2002. Following a review of submissions from key stakeholders

and members of the community by the subcommittee, a proposal for a draft Code of Practice was submitted to the Board for consideration. From this proposal, a draft was finalised and comment was invited from interested parties on its content. Recommendations submitted were then reviewed by the subcommittee and forwarded to the board for further consideration. The Code of Practice came into full effect on August 1, 2002.

DENTAL PROSTHETISTS ADVISORY COMMITTEE

The role of this committee is to provide the Board with expert advice on dental care to be provided by registered dental prosthetists and other persons qualified as dental technicians.

The members of the committee were:

Mr Mark Clarke	(4 attendances)
Mr Ian Gibbs	(5 attendances)
Dr Ross Green (Board member)	(4 attendances)
Mr Craig McCracken (Board member)	(5 attendances)
Mr John Rogan	(4 attendances)
Mr Peter Vryonis	(5 attendances)

The committee's main achievements during the year were its contributions to the Board's drafting and publication, in May 2002 of Infection Control for Dental Prosthetists and the promulgation, in June 2002, of the new Code of Practice for Dental Prosthetists, which is reprinted elsewhere in this report.

As a result of extensive debate on such topics as shade taking and the non-registration of dental technicians, the committee was active in putting issues forward to the Board for consideration. Both those issues were still being discussed at year's end.



AUDITOR GENERAL
VICTORIA

8 November 2002

Contact: Keith Barnes Telephone: 8601 7006
File No: 35.01.02.164/1

Mr P. Gardner
Chief Executive Officer
Dental Practice Board of Victoria
Level 14
114 Albert Road
South Melbourne 3205

Dear Mr Gardner,

I enclose for your information the audited financial report of the Dental Practice Board of Victoria for the year ended 30 June 2002. An unqualified opinion on the Board's financial report was issued on 8 November 2002.

A copy of the audited financial report and the audit opinion have been forwarded to the Minister for Finance, the Minister for Health, the Secretary to the Department of Treasury and Finance, the Secretary to the Department of Human Services and the President of the Board.

A management letter outlining the audit observations and recommendations identified in the audit will be issued shortly.

I would like to express my appreciation for the courtesy and co-operation extended by your staff during the audit.

Yours sincerely,

J W Cameron
Auditor-General

Victorian Auditor-General's Office Level 34, 140 William Street, Melbourne Victoria 3000
Telephone (03) 8601 7000 Facsimile (03) 8601 7010 Email comments@audit.vic.gov.au Website www.audit.vic.gov.au

Auditing in the Public Interest



AUDITOR GENERAL
VICTORIA

AUDITOR-GENERAL'S REPORT

To the Members of the Parliament of Victoria, responsible Ministers and Members of the Dental Practice Board of Victoria

Audit Scope

The accompanying financial report of the Dental Practice Board of Victoria for the financial year ended 30 June 2002, comprising a statement of financial performance, statement of financial position, statement of cash flows and notes to the financial statements, has been audited. The Members of the Board are responsible for the preparation and presentation of the financial report and the information it contains. An independent audit of the financial report has been carried out in order to express an opinion on it to the Members of the Parliament of Victoria, responsible Ministers and Members of the Board as required by the *Audit Act 1994*.

The audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance as to whether the financial report is free of material misstatement. The audit procedures included an examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial report, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial report is presented fairly in accordance with Accounting Standards and other mandatory professional reporting requirements in Australia and the financial reporting requirements of the *Financial Management Act 1994*, so as to present a view which is consistent with my understanding of the Board's financial position, financial performance and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

Audit Opinion

In my opinion, the financial report presents fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the financial reporting requirements of the *Financial Management Act 1994*, the financial position of the Dental Practice Board of Victoria as at 30 June 2002, its financial performance and cash flows for the year then ended.

MELBOURNE
8 November 2002


J.W. CAMERON
Auditor-General

Victorian Auditor-General's Office Level 34, 140 William Street, Melbourne Victoria 3000
Telephone (03) 8601 7000 Facsimile (03) 8601 7010 Email comments@audit.vic.gov.au Website www.audit.vic.gov.au

Auditing in the Public Interest

DENTAL PRACTICE BOARD OF VICTORIA

CERTIFICATION

In our opinion the financial report of the Dental Practice Board of Victoria, comprising statement of financial performance, statement of financial position, statement of cash flows and notes to the financial report:

- (i) have been prepared in accordance with Directions of the Minister of Finance under the Financial Management Act 1994 and Australian Accounting Standards; and
- (ii) present fairly the results of the financial transactions of the Board for the year ended 30th June 2002 and the financial position as at that date.

At the date of signing this report we are not aware of any circumstances which would render any particulars included in the statements to be misleading or inaccurate.



G D Condon
Deputy President



P M Gardner
Chief Executive Officer

Signed at Melbourne this 4th day of November, 2002.

DENTAL PRACTICE BOARD OF VICTORIA STATEMENT OF FINANCIAL POSITION

AS AT 30TH JUNE 2002

	NOTE	2002 (\$)	2001 (\$)
CURRENT ASSETS			
Cash Assets	11	734,993	572,383
Prepayments		6,064	4,547
Receivables		15,315	19,201
TOTAL CURRENT ASSETS		756,372	596,131
NON CURRENT ASSETS			
Plant & Equipment	4	70,772	47,741
Receivable		14,216	14,216
TOTAL NON CURRENT ASSETS		84,988	61,957
TOTAL ASSETS		841,360	658,088
CURRENT LIABILITIES			
Unearned Income - fees in Advance	1(f)	448,015	393,679
Payables	7	138,234	87,740
Lease Liability	8	4,228	3,824
Provisions	5	35,624	32,822
TOTAL CURRENT LIABILITIES		626,101	518,065
NON CURRENT LIABILITIES			
Lease Liability	8	7,792	11,906
Provisions	5	15,963	17,211
TOTAL NON CURRENT LIABILITIES		23,755	29,117
TOTAL LIABILITIES		649,856	547,182
NET ASSETS		191,504	110,906
EQUITY			
Contributed Capital	6(a)	176,401	176,401
Retained Profits (Losses)	6(b)	15,103	(65,495)
TOTAL EQUITY		191,504	110,906

The accompanying Notes form part of this Financial Report.

DENTAL PRACTICE BOARD OF VICTORIA STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30TH JUNE 2002

	NOTE	2002 (\$)	2001 (\$)
Revenue from Ordinary Activities	2	934,693	659,964
Employee Costs		(263,197)	(246,267)
Depreciation and amortisation		(16,533)	(7,479)
Written Down Value of disposed equipment		(1,247)	-
Investigation and law costs		(186,958)	(141,946)
Attendance fees & meeting expenses		(103,323)	(80,741)
Rent and utilities		(67,671)	(63,982)
Australian Dental Council per capita contribution		(41,827)	(38,010)
Printing & Stationery		(36,591)	(36,650)
Advertising		(25,456)	-
Accounting Fees		(19,153)	(13,851)
Other expenses from ordinary activities	3	(92,139)	(96,533)
Total expenses from ordinary activities		(854,095)	(725,459)
Net Result from Ordinary Activities		80,598	(65,495)
Total Changes in Equity other than Transactions with Owners		80,598	(65,495)

The accompanying Notes form part of this Financial Report.

DENTAL PRACTICE BOARD OF VICTORIA STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30TH JUNE 2002

	NOTE	2002 (\$)	2001 (\$)
Cash flows from operating activities			
Receipts from dental care providers		917,310	812,378
Interest Received		19,895	21,862
Other Receipts		82,931	31,183
Payments to Suppliers (Inclusive of GST) and Employees		(814,062)	(666,537)
Net cash inflow from operating activities	11(b)	206,074	198,886
Cash flows from investing activities			
Transfer from Antecedent Bodies		-	393,143
Plant and Equipment Purchases		(40,811)	(19,331)
Lease Payment		(3,710)	(315)
Proceeds on sale of fixed assets		1,057	-
Net cash provided (used) from investing activities		(43,464)	373,497
Net increase in cash held		162,610	572,383
Cash at the beginning of the financial year		572,383	-
Cash at the end of the financial year	11(a)	734,993	572,383

The accompanying Notes form part of this Financial Report.

DENTAL PRACTICE BOARD OF VICTORIA NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30TH JUNE 2002

NOTE 1: STATEMENT OF ACCOUNTING POLICIES

This general-purpose Financial Report has been prepared in accordance with the *Financial Management Act 1994*, Australian Accounting Standards, Statements of Accounting Concepts, and other authoritative pronouncements of the Australian Accounting Standards Board, and Urgent Issues Group Consensus Views.

The Financial Report is prepared in accordance with the historical cost method convention. Long service leave is measured at net present value. The accounting policies adopted, and the classification and presentation of items, are consistent with those of the previous year, except where a change is required to comply with an Australian Accounting Standard or Urgent Issues Group Consensus View. Where practicable, comparative amounts are presented and classified on a basis consistent with the current year.

(a) Rounding

All amounts shown in the financial statements are expressed to the nearest dollar.

(b) Leased Non-Current Assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased non-current assets, and operating leases under which the lessor effectively retains substantially all such risks and benefits.

Finance leases are capitalised. A lease asset and liability are established at the present value of minimum lease payments. Lease payments are allocated between the principal component of the lease liability and the interest expense.

The lease asset is amortised on a straight line basis over the term of the lease, or where it is likely that the entity will obtain ownership of the asset, the life of the asset. Lease assets held at the reporting date are being amortised over 5 years.

Other operating lease payments are charged to the statement of financial performance in the periods in which they are incurred, as this represents the pattern of benefits derived from the leased assets.

(c) Plant & Equipment

(i) Depreciation of Plant and Equipment

(ii) Non current physical assets with a cost in excess of \$1,000 are capitalised and depreciated. The expected useful life of all fixed assets are reviewed on an annual basis. The following straight line depreciation rates are expected to write-off the cost of each item of plant and equipment over its expected useful life to the board.

Class of Asset	Depreciation Rate	
	2002	2001
Furniture, Fixtures & Fittings	13%	13%
Computer & Office Equip.	17-20%	17-20%
Leased Plant & Equipment	20%	20%

(ii) Acquisition of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

(d) Income Tax

As an exempt body of the State Government of Victoria, the Board is not subject to income tax under S23(d) of the Income Tax Assessment Act 1936.

(e) Employee Benefits

Provision is made for the Board's liability for employee entitlements arising from services rendered by employees to balance date in accordance with Australian Accounting Standard AAS 30 "Accounting for Employee Entitlements". Employee entitlements expected to be settled within one year have been treated as a current liability and have been measured at their nominal amount. Other employee entitlements payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those entitlements. On costs comprising workcover and superannuation have been included in the calculation of employee entitlements.

(f) Unearned Income

The fees charged for registrations cover the period 1 January 2002 to 31 December 2002. As a consequence, at 30 June 2002 six months fees have been received in advance and are treated as a liability, being unearned income. Other items of revenue are recognised as income upon receipt.

(g) Good and Services Tax

Revenues, expenses and assets are recognised net of GST except where the amount of GST incurred is not recoverable, in which case it is recognised as part of the cost of acquisition of an asset or part of an item of expense or revenue. GST receivable from and payable

to the Australian Taxation Office (ATO) is included in the statement of financial position. The GST component of a receipt or payment is recognised on a gross basis in the statement of cash flows in accordance with Accounting Standard AAS 28.

(h) Contributed Capital

Consistent with UIG Abstract 38 "Contributions by Owners Made to Wholly-Owned Public Sector Entities" and Accounting and Financial Reporting Bulletin 39 "Accounting for Contributed Capital", transfers that are in the nature of contributions or distributions, have been designated as contributed capital.

Change in Accounting for Contributed Capital

In previous reporting periods up to 30 June 2001, the following items were recognised as revenues and expenses in the statement of financial performance:

- Assets received and provided free of charge from and to other government entities, and
- Grants received from other government entities for capital purposes.

Previously, in certain circumstances the Minister for Finance has granted an exemption to treat these items as a contributed capital.

For reporting period ending 30 June 2002, these transactions between wholly owned public sector entities, are now recognised in the statement of financial position as adjustments to net assets at the sector level but have no effect on the net assets at the whole-of-government level.

This change in accounting policy for transfers of assets and liabilities is in compliance with the accounting requirements of Urgent Issues Group Abstract 38 "Contributions by Owners Made to Wholly-Owned Public Sector Entities" and the accounting and Financial reporting (AFR) Bulletin No. 39 "Accounting for Contributed Capital"

(i) Payables

These amounts represent liabilities for goods and services provided prior to the end of the financial year and which are unpaid. Normal credit terms are net 30 days from statement date.

NOTE 2: REVENUE

	2002 (\$)	2001 (\$)
Operating revenue		
Registrations	862,974	599,595
Certificate fees and further particulars	2,942	2,802
Fines	46,213	12,803
Sale of address labels and lists of dentists	3,229	4,654
Other	1,542	13,726
	916,900	633,580
Non-operating revenue		
Interest received	17,793	26,384
	17,793	26,384
Total Revenue from Ordinary Activities	934,693	659,964

**NOTE 3:
NET RESULT FROM ORDINARY ACTIVITIES**

Net Result from Ordinary Activities has been determined after:

(a) Expenses

Remuneration of Auditor General audit services	4,600	8,500
Total remuneration	4,600	8,500
Rental expense on operating leases		
minimum lease payments	13,743	19,005
Other	73,796	82,879
	92,139	96,533

NOTE 4: PLANT & EQUIPMENT

	2002 (\$)	2001 (\$)
At Cost:		
Furniture, Fixtures & Fittings	42,786	8,343
Less Accumulated Depreciation	(17,196)	(1,828)
	25,590	6,515
Computer & Office Equipment	75,981	32,292
Less Accumulated Depreciation	(40,990)	(5,484)
	34,991	26,808
Leased Plant & Equipment	14,585	14,585
Less Accumulated Amortisation	(4,394)	(167)
	10,191	14,418
Total Plant & Equipment	70,772	47,741

(a) Movements in Carrying Amounts

Movements in carrying amounts for each class of plant and equipment between the beginning and the end of the current financial year.

	2002 (\$)	2001 (\$)
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(b) Disposal of Computer and Office Equipment

Written Down Value	1,247	-
Less Sale Proceeds	1,056	-
Loss on Disposal	191	-

	Furniture, fixtures & fittings	Computer & office equipment	Leased plant & equipment	TOTAL
	\$	\$	\$	\$
Balance at the beginning of the year	6,515	26,808	14,418	47,741
Additions	22,429	18,382	-	40,811
Disposals	-	(1,247)	-	(1,247)
Depreciation expense	(3,354)	(8,952)	(4,227)	(16,533)
Carrying amount at the end of the year	25,590	34,991	10,191	70,772

NOTE 5: PROVISIONS

Current		
Annual Leave	33,850	32,822
Long Service Leave	1,774	-
	<u>35,624</u>	<u>32,822</u>
Non Current		
Long Service Leave	15,963	17,211

	2002	2001
	(\$)	(\$)

NOTE 6: EQUITY

(a) Contributed Capital	176,401	176,401
(b) Retained Profits		
Retained Profits (Losses)		
at the beginning		
of the financial year	(65,495)	-
Net Profit (Loss)		
attributable to owners	80,598	(65,495)
Retained Profits (Losses)		
at the end of the financial year	15,103	(65,495)

NOTE 7: PAYABLES

Audit Fees	5,170	4,500
Employment Expenses	55,082	49,033
Sundry Expenses	63,494	20,478
Superannuation	14,488	13,729
	<u>138,234</u>	<u>87,740</u>

NOTE 8: LEASE COMMITMENTS

(a) Finance Lease Commitments

Payable		
- not later than 1 year	5,150	5,150
- later than 1 year but		
not later than 5 years	8,593	13,855
Minimum lease payments	13,743	19,005
Less future finance charges	(1,723)	(3,275)
Total Lease Liability	<u>12,020</u>	<u>15,730</u>

Current	4,228	3,824
Non Current	7,792	11,906
	<u>12,020</u>	<u>15,730</u>

Finance leases are for a photocopier and ancillary software.

	2002	2001
	(\$)	(\$)

(b) Operating Lease Commitments

Non cancellable operating leases on equipment and premises contracted for but not capitalised in the financial statements.

Payable		
- not later than 1 year	52,496	50,073
- later than 1 year but not		
later than 5 years	24,895	77,062
	<u>77,391</u>	<u>127,135</u>

NOTE 9: CAPITAL AND OTHER COMMITMENTS

(a) At 30 June, 2002 the Board had no outstanding capital commitments. (2001-Nil)

(b) At 30 June, 2002 the Board had no outstanding other commitments. (2001-Nil)

NOTE 10: RESPONSIBLE PERSONS RELATED DISCLOSURE

(a) Responsible Minister

The Hon. John Thwaites - Minister for Health is the Responsible Minister.

(b) Members of the Board

The following Responsible persons held positions as Members of the Board during the year.

Anthony J Dickinson President

Deborah J Cole

Antony Edwards

Gerard D Condon

Ross P Green

Jack H Harty

Pamela Leong appointed 25/06/2002

Gabrielle MacTiernan

Craig J McCracken

Anthony D Robertson

Loula S Rodopoulos

Julie G Satur resigned 30/03/2002

(c) Remuneration of Responsible Persons

The total remuneration paid to Board Members of the Dental Practice Board of Victoria was \$108,921.

Band of income of Board Members (\$)	No. of Board Members
	2002
1 - 9,999	8
10,000 - 19,999	3
	11

(d) Related Party Transaction

There were no related third party transactions during the year.

(e) Remuneration of Chief Executive Officer

Total remuneration paid to the chief executive officer.

Band of income Chief Executive Officer

(f) Superannuation

Superannuation contributions are paid at the required rate of 8 %. Superannuation contributions by the Board are as follows:

Name of Scheme	2002 Contribution for year	2002 Contribution outstanding	2001 Contribution for year	2001 Contribution outstanding
Anthony Dickinson Super Fund	-	759	-	683
Local Authorities Superannuation	-	243	-	358
MacKenzie Fund Administrators	-	999	-	525
Ross Green Nominees P/L Super Fund	-	615	-	512
AMP Life Limited	-	1,037	-	487
Health Super Pty Ltd	-	371	-	410
Government Superannuation Office	-	666	-	535
Anthony D Robertson P/L Super Fund	-	461	-	709
M L C Limited	-	-	-	128
Antony P Edwards Super Fund	-	359	-	-
George Rodopoulos Super Fund	-	1,165	-	538
Unisuper Management Pty Ltd	-	372	-	589
Professional Provident Fund ADAVB	-	6,119	3,114	5,181
M L C Investments	-	211	-	296
Norwich Union Life Australia Ltd	5,557	1,111	-	2,778
	\$5,557	\$14,488	\$3,114	\$13,729

NOTE 11: STATEMENT OF CASH FLOWS

	2002 (\$)	2001 (\$)
(a) Reconciliation of Cash		
For purposes of the statement of cash flows, cash includes cash on hand, at bank and on deposit.		
Cash on hand	45	328
Cash at bank	191,760	32,781
Cash on deposit	543,188	539,274
	734,993	572,383

(b) Reconciliation of net result from ordinary activities to net cash inflow from operating activities

Net result from ordinary activities	80,598	(65,495)
- Depreciation and amortisation	16,533	7,479
- Net Loss on disposal of equipment	191	-

Changes in Assets and Liabilities:

- (Increase)/Decrease in prepayments	(1,518)	(4,547)
- (Increase)/Decrease in receivables	3,886	(17,450)
- Increase/(Decrease) in payables	104,830	269,175
- Increase/(Decrease) in provisions	1,554	9,724

Net cash provided by operating activities	206,074	198,886
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(c) The Board has no credit stand-by or financing facilities in place.

(d) There were no non-cash financing or investing activities during the period.

NOTE 12: FINANCIAL INSTRUMENTS

(a) Interest Rate Risk

The Board's exposure to interest rate risk, which is the risk that a financial instrument's value will fluctuate as a result of changes in market interest rates and the effective weighted average interest rates on those financial assets and financial liabilities, is as follows:

	Floating Interest Rate		Fixed Interest Rate		Non Interest Bearing		Total carrying amount as per Statement of Financial Position		Range of effective Interest Rates	
	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001
Financial Instruments	\$	\$	\$	\$	\$	\$	\$	\$	%	%
Financial Assets										
Cash									1.0	1.25
Assets	303,497	168,318	431,496	404,065			734,993	572,383	to	to
Receivables									3.5	3.9
- Current					15,315	19,201	15,315	19,201	N/A	N/A
- Non Current	14,216	14,216					14,216	14,216	1.3	1.5
Total										
Financial assets	317,713	182,534	431,496	404,065	15,315	19,201	764,524	605,800		
Financial Liabilities										
Payables					138,234	87,740	138,234	87,740	N/A	N/A
Interest Bearing Liabilities										
- Current			4,22	3,824			4,22	3,82	9.	9.6
- Non Current			7,792	11,906			7,792	11,906	9.6	9.6
Total										
Financial Liabilities			12,020	15,730	138,234	87,740	150,254	103,470		

(b) Net fair Values

Methods and assumptions used in determining net fair value.

The net fair values of listed investments have been valued at the quoted market bid price at balance date adjusted for transaction costs expected to be incurred. For other assets and other liabilities the net fair value approximates their carrying value. No financial assets and financial liabilities are readily traded on organised markets in standardised form. Financial assets where the carrying amount exceeds net fair values have not been written down as the board intends to hold these assets to maturity.

(b) Net fair Values (cont)

The aggregate net fair values and carrying amounts of financial assets and financial liabilities are disclosed in the balance sheet and in the note to and forming part of the financial statements.

	Total carrying amount as per Statement of Financial Position		Aggregate net fair value	
Financial Instruments	2002 \$	2001 \$	2002 \$	2001 \$
Financial Assets				
Cash Assets	734,993	572,383	734,993	275,383
Receivables				
- Current	15,315	19,201	15,315	19,201
- Non Current	14,216	14,216	14,216	14,216
Total Financial Assets	764,524	605,800	764,524	605,800
Financial Liabilities				
Payables	138,234	87,740	138,234	87,740
Interest-bearing liabilities				
- Current	4,228	3,824	4,228	3,824
- Non Current	7,792	11,906	7,792	11,906
Total Financial liabilities	150,254	103,470	150,254	103,470

(c) Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognise financial assets is the carrying amount, net of any provisions for doubtful debts, as disclosed in the statement of financial position and notes to the financial statements.

The Board does not have any material credit risk exposure to any single debtor or group of debtors under financial instruments entered into by the Board.

NOTE 13: CONTINGENT LIABILITIES

As at 30 June 2002, the Board has three legal cases outstanding in relation to its role of administering The *Dental Practice Act 1999*. Additional legal costs may be incurred if these cases were to be appealed.