Dental Practice Board of Victoria

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DECISION:

DR URMAS AAVELAID (DENTIST)

JANUARY 29TH, FEBRUARY 25TH, 26TH, 27TH, APRIL 8TH, 9TH, 11TH, MAY 13TH, 14TH, 15TH, JUNE 4TH, 5TH, 21ST. AUGUST 19TH AND SEPTEMBER 16TH 2002.

Panel: Mr. J. Harty
Dr. G. Condon
Adj. Prof. L.S. Rodopoulos

The Panel, after considering all the submissions made into the professional conduct of Dr. Aavelaid found that he had:

1 provided dental treatment to the following patients over the period from May 2000 to September 2001:Mrs NN; Ms. ER; Mr. LT; Mr TS; Mrs. LS; Mr. DE; Mrs. NL; Mrs. AR; Ms EN; Ms RE; and

(a) failed to obtain the prior consent (fully and appropriately informed) of those patients to that dental treatment being performed;

(b) failed to provide those patients with all necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed, and the cost of that treatment, before commencing the treatment; and

(c) failed to ensure that his patients understood what treatment they were consenting to.

Accordingly the Panel found Aavelaid to be guilty of unprofessional conduct (as defined in Section 3 of the *Dental Practice Act 1999*), of a serious nature and of professional misconduct under Section 25 of the *Dentists Act 1972*.

2 Provided endodontic dental treatment to the following patients over the period of May 2000 to September 2001; Mr. EE; Mrs. NL; Mr. DE; Mrs. LS; Mrs AY; and Mr TS; and that

(a) The quality of the endodontic treatment which he provided to these patients was:

- Extremely poor;
- Grossly substandard;
- Of a lesser standard than that which the public might reasonably expect of a registered dental care provider;
- Of a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers; and
- Of a substantially lower standard than that observed or approved by members of the dental profession of good repute and competency. And also that

(b) he did not use rubber dam when performing endodontic procedures for these patients, and did not routinely do so when performing endodontic procedures;

Accordingly the Panel found Dr. Aavelaid to be guilty of unprofessional conduct (as defined in Section 3 of the *Dental Practice Act 1999*), of a serious nature and of professional misconduct under Section 25 of the *Dentists Act 1972*.

Failed to properly 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 at 47 Thompson Street, Hamilton.

Accordingly the Panel found Dr. Aavelaid to be guilty of unprofessional conduct (as defined in Section 3 of the *Dental Practice Act 1999*), of a serious nature.

Maintained dental records in regard to the treatment of his patients which were inadequate and defective, and did not comply with the stated policy on record keeping of the Dental Board of Victoria and the interim code of practice related to dental records of the Dental Practice Board of Victoria.

Accordingly the Panel found Dr. Aavelaid to be guilty of unprofessional conduct (as defined in Section 3 of the *Dental Practice Act 1999*), of a serious nature and of professional misconduct under Section 25 of the *Dentists Act 1972*.

The Panel considers the determination options function to maintain the high standards of the dental care profession, and to act as a specific and a general deterrent. General deterrence in this case functions to ensure that other dental care providers do not adopt a similar approach to their dentistry and patients to that which Dr. Aavelaid has. The patients who complained to the Board need to be reassured that the Board is vigilant in maintaining the minimum standards required of a dental care provider. Specifically the determination must rectify any damage to the image of the profession caused by Dr. Aavelaid and ensure that Dr. Aavelaid understands that his approach to his patients and aspects of his clinical dentistry have been detrimental to the public and expose patients to significant risk.

The Panel found that Dr. Aavelaid was not a credible witness and showed no insight into his behaviour when treating patients entrusted to his care. Counsel assisting the Panel pointed out that Dr. Aavelaid had broken his agreement with Judge Knight in New South Wales regarding the need for written patient consent, and noted that he undertook mandated retraining in New South Wales in 1998 only after his attempts to gain registration in Victoria had failed.

Dr Aavelaid's counsel suggested various conditions which could be placed upon Dr. Aavelaid's registration. These included use of a consent document mentioned above, modification to his endodontic technique and record keeping, and auditing. In the Panel's view, Dr. Aavelaid's history with a similar agreement, together with its experience of his approach to patients and dentistry as evident in this case, clearly indicated that the Panel could not be satisfied that these conditions would be complied with. The Panel considered the likelihood of repetition of this behaviour to be high, to the detriment of the public.

The Panel also concurred with argument that the "principle of totality" should apply for all allegations proven.

Accordingly the Panel made the following determinations:

1. For the lack of informed consent issues the Panel imposed a fine of $10,000.00;

2. For the poor endodontic treatment issues the Panel imposed a fine of $10,000.00;

3. For the drugs and poisons issues the Panel imposed a fine of $3,000.00**;**

4. For the inadequate and defective dental records the Panel imposed a fine of $5,000.00.

5. The fines in their totality were to be paid within seven days of the date of the determination.

6. The Panel immediately suspended the registration of Dr. Aavelaid until 31 December 2009.