

THE DENTAL PRACTICE BOARD OF VICTORIA

Dr Leonid Exler [2009] DPBV 1

Panel: Mr Peter Hardham (Chair)
Dr Pam Dalgliesh
Dr Vlad Hardi

Counsel Assisting the Panel: Mr P Monahan of Monahan + Rowell, Lawyers

Counsel for the Practitioner: Mr I Freckelton SC

Dates of Hearing: 27 and 28 January 2009

Date of Decision: 15 April 2009

FINDINGS

Findings

The Panel finds that the allegations set out in Paragraphs G - E have been made out, in relation to the first patient. That the allegations contained in Paragraphs W, X, Y, Z, AA, BB, CC and DD have been made out. The Panel does not find the allegations set out in Paragraph EE to have been made out. The Panel finds the allegations contained in Paragraph FF have been made out. The Panel finds the allegations contained in Paragraph JJ and KK, LL, MM, NN, OO, PP, QQ, RR, SS and TT have been made out. The Panel is satisfied the allegations contained in Paragraphs UU, VV, WW, XX, YY, ZZ, AAA, BBB and CCC have been made out.

Determinations

1. Dr Exler has undertaken not to apply for re-registration as a dental practitioner until 1 January 2010. The Panel made the following determinations. Pursuant to s.47(2)(a) of the *Dental Practice Act 1999* that Dr Exler undergoes both lectures and hands-on courses in the area of prosthodontics, including treatment planning, endodontics, management of cracked cusps and infection control and that these courses be completed within six months of Dr Exler obtaining re-registration. The courses are to be approved by the Board and are to be at Dr Exler's expense.
2. In accordance with s.47(2)(b) of the Act that Dr Exler is specifically cautioned in relation to obtaining informed consent from his patients, both in terms of the treatment to be provided, the method of treatment and the fees to be charged and the method of communication with patients.

3. In accordance with s.47(1)(c) of the Act that Dr Exler is formally reprimanded for his failure to exercise proper clinical judgment in relation to his treatment of Patient A.
4. That in accordance with s.47(2)(e) of the Act the Panel imposes the following conditions of Dr Exler. In the event that he is re-registered namely, that he undertake and participate in courses in relation to record keeping and obtaining informed consent with his patients. The course is to be approved by the Board and to be undertaken at his expense within six months of re-registration. That he is to be the subject of a random audit of all his dental practices within a period of 12 months of him obtaining re-registration at all places at which he undertakes professional practice.
5. That in accordance with 47(2)(f) of the Act the Panel, (a) imposes a fine of \$5000 on Dr Exler with respect to his failure to respond to the letters received from the Board and (b) a further fine of \$5000 for his failure to comply with the professional requirements expected of him in relation to his dealings with Patient A, such fines to be paid within six months of the publication of these reasons.

Reasons for Decision

1. On 27th and 28 January 2009 a Panel appointed by the Dental Practice Board of Victoria conducted a formal hearing into the professional conduct of Dr Leonid Exler, formally a registered dental care provider.
2. A Notice of Formal Hearing dated 2 December 2008, alleged that Dr Exler had engaged in unprofessional conduct within the meaning of, "Unprofessional conduct" as set out in s.3 of the *Dental Practice Act 1999*.
3. The allegations against Dr Exler are as follows:
 - (a) At all relevant times, you have been registered as a dental care provider in Victoria under the *Dental Practice Act 1999* ("the Act") having been first registered as a dentist in Victoria in October 1990.

A. YOUR PATIENTS

- (b) On 1 February 2007, you provided dental treatment to your patient, Mr NN.
- (c) During February 2007, you provided dental treatment to your patient, Dr BB.
- (d) On 19 February 2007, you provided dental treatment to your patient, Mrs GG.

B. YOUR PATIENT – MR NN

- (e) You provided dental treatment to Mr NN at your dental clinic at 20 Railway Crescent, Broadmeadows in an emergency appointment on the evening of 1 February 2007.
- (f) You provided the following treatment to tooth 46 of Mr NN:
 - (i) removal of broken part of the tooth;
 - (ii) placing calcium hydroxide;
 - (iii) placing a filling to restore the broken part of the tooth;
 - (iv) preparing the tooth and placing a temporary crown on tooth 46;
 - (v) taking an impression for a future permanent crown; and

Poor Dental Work

- (g) The dental work which you provided to Mr NN was:
 - (i) extremely poor;
 - (ii) grossly substandard;
 - (iii) of a lesser standard than that which the public might reasonably expect of a registered dental care provider; and
 - (iv) of a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers.
- (h) In particular, the dental work which you provided was deficient in the following respects:
 - (i) Your management of Mr NN's pain was very poor in that you administered four anaesthetic injections which were ineffective.
 - (ii) Your treatment plan was incorrect, in that you did not allow first for root canal therapy on tooth 46 before placing the crown.
 - (iii) You placed a small amount of composite over a pulp exposure on tooth 46 when it was not appropriate to do so.

- (iv) Having diagnosed (and informed Mr NN of this diagnosis) that the nerve in tooth 46 was exposed, you proceed to fit a temporary crown rather than recommend and commence root canal treatment on that tooth before fitting the crown.
- (v) You accordingly proposed to fit a permanent crown, on tooth 46 in circumstances where it was not reasonable or appropriate to do so.
- (vi) The temporary crown that you made and fitted was grossly over contoured and too thin.
- (vii) The preparation for tooth 46 was inappropriate in that there was insufficient restoration/core material in the mesiolingual region of the tooth.
- (viii) The crown preparation on tooth 46 contained inadequate margins, especially in the mesiolingual and distolingual areas.
- (i) Your conduct set out above constituted unprofessional conduct as defined in Section 3 of the Act.
- (j) Such unprofessional conduct was of a serious nature.

Information and consent

- (k) Prior to commencing the treatment (and during the course of the treatment), you failed to provide Mr NN with all the necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed.
- (l) In particular, you failed to inform Mr NN that:-
 - (i) it was inappropriate to fit a crown on this tooth (tooth 46) where the nerve was exposed.
 - (ii) in the circumstances, the most appropriate treatment option was to perform root canal treatment before fitting a crown.
 - (iii) it was inappropriate in the circumstances to perform root canal treatment on that tooth after a crown had been placed, and that was not a sensible or realistic option.
 - (iv) there was a high probability that the tooth would become infected, that antibiotics would be unlikely to solve the problem permanently and that root canal treatment would most likely be required.
- (m) Your conduct set out above constituted unprofessional conduct as defined in Section 3 of the Act.
- (n) Such unprofessional conduct was of a serious nature.

Infection Control

- (o) On 1 March 2005, the Dental Practice Board of Victoria ("*the Board*") promulgated Code of Practice number C006 about the practice of dentistry, entitled "*Infection Control*", under Section 69(1)(e) of the Act.
- (p) At that time, and thereafter, this Code of Practice was widely publicised within the dental profession in Victoria, initially during or about March 2005, by being posted to all registered dental care providers in Victoria, and thereafter by being posted on the Board's website.
- (q) A copy of the Infection Control Code of Practice number C006 is attached **marked "A"**.

- (r) The Code of Practice requires in paragraph 8 that every registered dental care provider must:
 - (i) Ensure the premises in which he or she practises are kept in a clean and hygienic state to prevent the spread of infectious disease;
 - (ii) Ensure that in attending a patient, he or she takes such steps as are practicable to prevent or contain the spread of infectious disease; and
 - (iii) Act in accordance with the requirements set out in the three documents referred to at paragraph 7 of the Code of Practice (namely the Practice Manual, AS / NZS 4815:2001 and the Commonwealth Government Publication "Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the health care setting" (published January 2004).
- (s) You are in breach of the Code of Practice. You have breached your obligations under paragraph 8 of the Code of Practice in the following respects:-
 - (i) You did not wear gloves while treating Mr NN.
 - (ii) You did not wear a mask while treating Mr NN.
 - (iii) You did not wear a gown while treating Mr NN.
- (t) Your conduct set out above constituted unprofessional conduct as defined in Section 3 of the Act.

C. YOUR PATIENT – DR BB

- (v) You provided dental treatment to Dr BB at your dental clinic at 1A Kent Avenue, Brighton on various occasions during February 2007, and in particular on 10 and 24 February.

False Accounts/Records

- (w) Copies of your accounts rendered to Dr BB for the treatment allegedly provided to her by you on those two days are attached **marked "B" and "C"**.
- (x) The account for 24 February 2007 was false in the following respects:-
 - (i) You rendered a charge for \$30 under ADA Item No. 213 under the description "*Treat Acute Perio Infection*" on tooth 27, when, in truth and in fact, you did not provide that treatment to your patient.
 - (ii) You rendered a charge of \$100 under ADA Item No. 534 under the description "*Adhesive Restoration – four surfaces – post*" on tooth 26, when, in truth and in fact, you did not provide that treatment to your patient.
 - (iii) You rendered a charge of \$60 under ADA Item No. 577 under the description "*Cusp Capping – Per Cusp*" on tooth 26, when, in truth and in fact, you did not provide that treatment to your patient.
 - (iv) You rendered a charge of \$50 under ADA Item No. 015 under the description "*Extended consultation*" when, in truth and in fact, you did not provide that treatment to your patient.
 - (v) You rendered a charge of \$30 under ADA Item No. 188 under the description "*Bleaching, external – per tooth*" when, in truth and in fact, you did not provide that treatment to your patient.

- (y) On 24 February 2007, immediately after receiving the said account, your patient Dr BB queried the account with you personally, expressing surprise about the reference to her having an infection. You responded by agreeing that she did not have an infection. You were accordingly fully aware of these facts at the relevant time.
- (z) At no material time was the account amended or withdrawn.
- (aa) Your account to Dr BB for 10 February 2007 was also false, in that you rendered a charge for \$120 under ADA Item No. 114 under the description "*Removal of calculus*", when, in truth and in fact, you did not provide that treatment to your patient.
- (bb) Alternatively, if you did in fact attempt to perform the "*Removal of calculus*" procedure described in ADA Item No. 114 on 10 February 2007, you did so in an extremely poor and grossly substandard manner, providing such dental service to Dr BB at a lesser standard than that which the public might reasonably expect of a registered dental care provider, and at a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers.
- (cc) Your letter to the Board dated 10 June 2007 concerning your account to Dr BB for 24 February 2007 was also false, in that you claimed to have rendered a charge for \$30 under ADA Item No. 111 ("*Removal of plaque and/or stain*") when, in truth and in fact, you did not provide that treatment to your patient and where it would have been completely unnecessary and inappropriate to perform such a procedure, if you had in fact performed the procedure under ADA Item No. 114 under the description "*Removal of Calculus*" two weeks earlier on 10 February 2007, as indicated in your earlier account of that date.
- (dd) You dishonestly amended, or instructed another person to amend, your dental records after the event, to change a reference from ADA Item No. 213 to ADA Item No. 111, or alternatively to attempt to do so.

Offensive and Inappropriate Behaviour

- (ee) Further, you behaved in an offensive, inappropriate and unacceptable manner with your patient Dr BB when she attended at your surgery on 26 February 2007, in the following circumstances and respects:
 - (i) Dr BB presented to your clinic in pain.
 - (ii) She asked you about the pain which she was experiencing, and whether it was normal.
 - (iii) You responded by telling her that she must make another appointment for a thorough examination and that a fish bone may have accidentally been near, around or in the filling causing the pain.
 - (iv) When Dr BB replied that she had not been eating fish, you then told her that her pain could be psychosomatic, and that she should make another appointment.
 - (v) You failed to give her any advice or assistance on that day in regard to the management of her pain.
 - (vi) You failed to maintain any record at all of Dr BB's attendance at your clinic on that occasion.

- (ff) Further, you behaved inappropriately when seeing Dr BB on 10 February 2007 in that:
- (i) She had already informed you and/or your staff that she did not want a whitening procedure.
 - (ii) You nevertheless placed Dr BB under considerable pressure to change her mind about that, and to instruct you to perform the whitening procedure on her.
 - (iii) In the course of applying that pressure on her, you pressed upon her that, because she had private health insurance, she would not be out of pocket in any significant way if she went ahead with the procedure.
 - (iv) You first told her that she would only be \$50 out of pocket, but later recanted this and said that she would be out of pocket by at the most \$100.
 - (v) You later rendered charges to her on 24 February 2007 totalling \$400 for the tooth whitening procedure, of which Dr BB only recovered \$200 from her private health insurance fund, leaving her \$200 out of pocket.

Conclusion

- (gg) Your conduct in all of these respects constituted unprofessional conduct as defined in Section 3 of the Act.
- (hh) Such unprofessional conduct was of a serious nature.

D. YOUR PATIENT – MRS GG

- (ii) You provided dental treatment to Mrs GG at your dental clinic at 1A Kent Avenue, Brighton, on 19 February 2007 relating to the restoration of teeth 11 and 21.

Poor Dental Work

- (jj) The dental work which you provided to Mrs GG was:
- (i) extremely poor;
 - (ii) grossly substandard;
 - (iii) of a lesser standard than that which the public might reasonably expect of a registered dental care provider; and
 - (iv) of a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers.
- (kk) In particular the dental work which you provided was deficient in the following respects:
- (i) You failed to diagnose and treat your patient's bruxism before commencing restorative treatment;
 - (ii) You failed to recommend the fabrication and application of a splint;
 - (iii) The fillings which you applied to teeth 11 and 21 fell out within days of your treatment;
 - (iv) One reason for this was that the restorations which you performed were too long and required further adjustment.
 - (v) The restorations you applied in teeth 11 and 21 were susceptible to failure without the use of a splint.

False Accounts

- (ll) You rendered an account to Mrs GG for the work which you allegedly performed on 19 February 2007, and a copy of your account is attached **marked "D"**.
- (mm) In that account, you rendered two charges, each of \$250, under ADA Item No. 524 under the description "*Adhesive Restoration – four surfaces – Anterior – Direct*" on teeth 11 and 21, when, in truth and in fact, you did not provide that treatment to your patient. Rather, the treatment which you provided to your patient constituted the treatment described under ADA Item Nos. 522 or 523.
- (nn) Your conduct in all of these respects constituted unprofessional conduct as defined in Section 3 of the Act.
- (oo) Such unprofessional conduct was of a serious nature.

Information/Consent

- (pp) You diagnosed Mrs GG as possibly suffering bruxism, noting on your records "*possible grinding at night*";
- (qq) However, prior to commencing the treatment (and during the course of the treatment), you failed to provide Mrs GG with all the necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed, relating to her bruxism.
- (rr) In particular, you failed to inform Mrs GG of the risks and possible complications of the treatment she was undertaking that could be caused by bruxism.
- (ss) Your conduct set out above constituted unprofessional conduct as defined in Section 3 of the Act.
- (tt) Such unprofessional conduct was of a serious nature.

E. FAILURE TO RESPOND TO THE BOARD

- (uu) Dr Anthony Roseman is the Investigative Officer of the Board, and the person to whom the Board has delegated its power to conduct preliminary investigations into complaints under Section 23 of the Act.
- (vv) In that capacity, and in the performance of his functions and duties as Investigative Officer of the Board, Dr Roseman wrote to you on the following occasions requesting documents and information about your treatment of your patients:

Mrs GG

Letters dated 2 April 2007, and 28 April 2007, your reply only being received on 14 May 2007.

Dr BB

Letters dated 13 April 2007, 15 May 2007 and 30 May 2007, your reply only being received on 12 June 2007.

Mr NN

Letter dated 14 March 2007, your reply only being received on 18 April 2007.

- (ww) You failed to respond to any of those letters within the time stipulated.

- (xx) You accordingly failed for a considerable and unreasonable period of time to provide Dr Roseman with your dental records or your written comments on the allegations made against you by these patients, and to answer Dr Roseman's reasonable inquiries.
 - (yy) By your conduct, you have sought to disrupt, and have disrupted, the performance by Dr Roseman of his functions and duties as Investigative Officer of the Board, and have inappropriately and unreasonably delayed the investigation of the complaints against you.
 - (zz) By your conduct, you have sought to frustrate, and have in part frustrated, the investigative and disciplinary functions of the Board.
 - (aaa) Your conduct in all of these respects constituted unprofessional conduct as defined in Section 3 of the Act.
 - (bbb) Such unprofessional conduct was in itself of a serious nature.
4. At the commencement of the hearing Dr Freckelton SC who appeared for Dr Exler, said that a number of the allegations were admitted and others were disputed. In terms of Patient A, Dr Exler disputed that his treatment of this patient was poor and sub-standard or of a lesser standard than would be expected of the public or Dr Exler's peers. He admitted a number of the treatment processes referred to in the notice, but he disputed that Dr Exler's overall treatment of this patient was unprofessional conduct of a serious nature.
 5. In terms of the Patient B, he admitted that the accounts submitted to her were incorrect. He stated Dr Exler had explanations as to why this occurred. He denied that he submitted incorrect accounts intentionally or that his conduct towards this patient in the rendering of accounts constituted unprofessional conduct. He disputed that the treatment he provided to this patient constituted unprofessional conduct or that the manner in which he dealt with the patient when she presented to his surgery without an appointment was of a lesser standard than would be expected of members of the public or Dr Exler's peers.
 6. In terms of the Patient C, whilst he admits that fillings which he applied to teeth 11 and 21 fell out within days of the treatment he provided to her, he disputed that his treatment of the patient was of a lesser standard than would be expected of members of the public or Dr Exler's peers. In respect of the accounts he submitted, he admitted that the accounts were incorrect but he provided an explanation in relation thereto. He also admitted that he diagnosed this patient as suffering from bruxism and that he failed to provide her with advice and information in relation to treatment and options but he denies any unprofessional conduct which may follow as a result thereof could be classified as unprofessional conduct of a serious nature.
 7. In relation to the allegations concerning his failure to respond to the Board's letters, he admits those allegations but he indicated he would be providing the Panel with an explanation in relation thereto. Nevertheless he admitted that his actions in failing to respond to the Board's letters i.e. the letters forwarded to him by Dr Roseman, constituted unprofessional conduct of a serious nature.
 8. Written and oral evidence of the first patient (hereinafter referred to as NN) was that on the evening of 1 February 2007 he cracked a tooth whilst eating dinner. He stated that prior to this incident he had not undertaken any dental treatment for 9.5 years. He said he made "An emergency appointment"¹ (page1 of his written notification) to see Dr Exler at 8.15 p.m. that evening. The narrative of events that occurred thereafter is well described at p.1 of this statement in the following terms.

¹ Exhibit D at page 80 - Book of Evidence

"Dr Exler made a preliminary examination, gave me an anaesthetic injection and took an X-Ray of the tooth and left the room to wait for the anaesthetic to take effect. On his return some minutes later I advised Dr Exler that the anaesthetic appeared not to be working well as I could still feel considerable pain.

Dr Exler administered another anaesthetic injection. He suggested that whilst we wait for the second injection to take place he takes X-Rays of the rest of my teeth, to which I agreed.

Dr Exler removed the portion of tooth that had cracked away and after examining the tooth advised me that the nerve was exposed. I asked Dr Exler for an explanation of this so he drew a picture of a tooth showing where the tooth had a portion missing and where the nerve was exposed.

Dr Exler recommended treatment that he fit a crown, which would cost approx \$1900. He stated that in cases of exposed nerves it is possible that the tooth gets infected and if the infection cannot be treated with antibiotics then root canal treatment would be required, which would be difficult and time consuming and would cost in the area of \$5000. He said that this could be done if necessary after the crown was fitted.

Given my inexperience, I accepted Dr Exler's recommendation to proceed with the crown treatment.

Dr Exler commenced treatment by touching the cracked tooth with what appeared to be a small cotton ball. The pain was still intense and so Dr Exler gave me a third injection.

After waiting for this third injection to take effect, Dr Exler re-commenced treatment. After some time he had to stop as the pain was still severe and give me a fourth injection.

The pain continued throughout the treatment and by the time Dr Exler had finished it was a few minutes past 11 pm. It was the most painful and unpleasant medical procedure that I have ever experienced."

9. He stated that Dr Exler's response to these matters was that, "it was a very difficult treatment for him and I must have an unusual metabolism for the 4 injections not to kill all the pain."² Dr Exler charged him \$1700 for the treatment and advised him to return in one to two weeks to complete the treatment when a further \$520 would be payable. He said that the charges would be higher than his initial quote because of the extensive time involved with the treatment. The patient was also provided with prescriptions for antibiotics and pain killers, and a further appointment was made for 16 February 2007 at 3.30 pm at his Balwyn clinic.
10. He stated that the "Shabby look of the surgery"³ and the pain he experienced and the cost involved caused him significant concern and he decided to obtain a second opinion. He eventually consulted a Dr Chris Gliddon. As a result of seeing Dr Gliddon he did not return to see Dr Exler. He also stated that during the consultation with Dr Exler he noticed that the dentist did not wear gloves, a mask or a gown while treating him and this was also the case with his staff. He also said that Dr Gliddon covered his neck and chest with shielding whilst taking X-rays and that he only administered one injection and he wore gloves, mask and a gown.
11. Dr Gliddon provided a report to the Board dated 8 May 2007 in which he stated that he saw the patient on 9 February 2007. He obtained a history from him that Dr Exler had removed the fractured cusp with tweezers exposing the pulp (the nerve) of the tooth and that the tooth was restored and immediately prepared for a crown. The patient also related the history to him of the considerable pain that he had experienced during the treatment with Dr Exler. Dr Gliddon said the patient asked him to provide an opinion in relation to the treatment received. In his report

² Exhibit D at page 80 - Book of Evidence

³ Exhibit D at page 81 - Book of Evidence

Dr Gliddon went on to state the following:

"I told him that I believed it to be unwise to crown over a pulp exposure, particularly as the tooth, whilst still vital, was not totally symptom free. I went on to say that, in my opinion, the most predictable outcome would be to perform endodontic therapy and then, a crown would be placed (in this case there was no option as the "preparation" had been done) when the tooth was totally symptom free, subject to satisfactory radiographic findings. He further told me that he had been advised that endodontic therapy could be performed if required, after crown placement, but that it would be very expensive. I told him that I believed that it is better to perform endodontic treatment prior to crowning."⁴

He also stated that in view of the history given by the patient of pulp exposure the pulp may become necrotic. Dr Gliddon said he saw the patient again on 1 March 2007 as Mr NN had to travel soon after the first appointment.

12. When he saw Mr NN again at that time he said he removed the temporary crown which he described as, "grossly over contoured and thin". He said he also took a radiograph of the affected tooth (No.46). It was agreed that RCT and a PFM crown (including a new core) would be the most appropriate treatment plan. In terms of his direct observations of the treatment that the patient had received from Dr Exler he went on to state:

"It was apparent that 47 had been significantly cut on its mesial surface during crown preparation and would require restoration. There was little evidence of restoration/core material in the ML region. RCT was performed over three visits. I believe that a small amount of composite covered an almost certain pulp exposure. There was no evidence of a pulp capping material being present.

A stainless steel para post was placed in the distal canal and a composite core constructed.

The iatrogenically sliced 47 was restored with composite and the crown was inserted on 24 April 2007, after adjusting the existing crown preparation which had inadequate margins especially in the ML and DL areas. The gingiva had been irritated by the over contoured temporary crown."⁵

13. The Board's Investigating Officer provided Mr NN's complaint to Dr Exler on 10 April 2007 and he ultimately responded by stating that he examined the patient's teeth, undertook numerous X-rays and he observed a large part of tooth 46 was broken, "With exposed dentine but no obvious pulp exposure." In terms of the advice he provided to the patient Dr Exler stated:

"As a standard protocol with emergency patient, RCT and crowning, extraction costs were thoroughly explained to Mr NN.

Mr NN was given a time to ask questions and after discussions he agreed to go ahead with a treatment consisting of preparing the tooth for the crown, placing the temporary crown, reviewing the tooth with possible root canal treatment and finally placing the permanent crown.

The pain control wasn't achieved initially and I had to administer more anaesthetics before Mr NN allowed me to work on the tooth."⁶

In his letter Dr Exler conceded he had considerable difficulty in achieving pain control and that he had to administer numerous anaesthetics. He went on the state that he was subsequently advised that the patient would not be returning.

⁴ Exhibit D at page 103 – Book of Evidence

⁵ Exhibit D at page 104 – Book of Evidence

⁶ Exhibit D at page 90 – Book of Evidence

He went on to describe the treatment that he provided as consisting of removal of the broken part of the tooth, placing calcium hydroxide on the tooth to protect the pulp, promote the development of secondary dentine and to try to avoid root canal treatment. He said he placed a filling on the tooth to restore the broken part of the tooth and placed a precise temporary crown on the tooth to protect the tooth and he took an impression for the proposed permanent crown.

14. He also stated that he provided the highest level of infection control and that he and his staff were wearing gloves all the time and that his staff are trained in infection control and that all of his staff, "Follows all the Dental Board Infection Control requirements."⁷ He said he took seven X-rays and that the treatment requirement was, "Complex".⁸
15. Dr Exler did not give evidence before the Panel but his counsel, Dr Freckelton SC provided the Panel with a detailed affidavit sworn by Dr Exler on 27 February 2009. In that affidavit Dr Exler stated that he had not been practising dentistry from 31 March 2008, "having experienced considerable stress as a result of these complaints, and other matters, and having decided, for my health, to take a break from practice."⁹
16. He repeated the description of his treatment to the patient as set out above. In terms of the allegations made by the patient he said that he administered three anaesthetics and that the patient did not give any indication either verbally or physically that he was in pain. He stated that in his opinion his treatment plan of the patient was appropriate. He stated in Paragraph 9(h)(ii) of his affidavit as follows:

"My treatment plan was appropriate. It was to attempt a temporary crown, moving toward a permanent crown if the temporary crown was successful, and that Mr NN did not experience further pain. Alternatively, as is apparent from my notes, if Mr NN did experience further pain or if there were any other difficulties, it was my plan to undertake root canal treatment."¹⁰
17. He stated he placed a small amount of temporary composite over the dentine exposure, not pulp exposure, on the tooth. He went on to state specifically at Paragraph 9(h)(iv).

"I did not inform Mr NN that the nerve on tooth 46 was exposed. I told him that the dentine was exposed and queried in my notes whether there was an exposed nerve."¹¹

Dr Exler said his advice to his patient was that it was worthwhile attempting a temporary crown and possibly a permanent crown, "All being well" rather than undertaking what he described as expensive root canal treatment. He said he told the patient the costs and also advised him that he proposed to fit a permanent crown if it was appropriate to do so.
18. He responded to the criticism directed towards him by Dr Gliddon that the temporary crown was, "Grossly contoured and thin" and in relation to the other criticism that there was, "Little evidence of restoration of the core material in the ML region", by stating that the crown he inserted was only a temporary crown and that he proposed to review the state of the tooth on the next appointment. He went on to describe his future treatment options and he concluded by stating, if there was to be any criticism of what was a short term option, "Perhaps one could say that it could have been less contoured, thicker, and with more material in the mesiolingual region."

⁷ Exhibit D at page 90 – Book of Evidence

⁸ Exhibit D at page 91 – Book of Evidence

⁹ Exhibit G at page 198 – Book of Evidence

¹⁰ Exhibit G at page 201 – Book of Evidence

¹¹ Exhibit G at page 201 – Book of Evidence

19. The Panel heard evidence from Mr NN. In addition to the matters referred to above he explained Dr Exler drew him a diagram which showed the crack in the tooth. The patient said that, "Dr Exler explained to me that there was a large crack in the tooth and that the crack had exposed a nerve."¹² He said his understanding of the treatment was that he was to ultimately have a permanent crown fitted, "My understanding was that it was a permanent fitting so if I turned up at the next appointment and there was no pain and no evidence of infection a permanent crown would be fitted and that would be the end of it". He said that the cost was stated to be \$1900. He said that Dr Exler was wearing a striped pink and white shirt, bow tie, dark trousers and shoes. He said he did not wear a mask or gloves.¹³
20. During the course of cross-examination by Dr Freckelton SC the patient stated that the reason why he went to see another dentist was because of, "Anxieties that he had about the situation."¹⁴ The Panel heard evidence from Dr Gliddon who stated that he had practised as a general dentist for 32/3 years. He stated that when he referred to pulp exposure, this was the same as stating that there was nerve exposure. He said that from his examination of the patient he observed that the tooth "had not been fully prepared for a permanent crown."¹⁵ He said that after he removed the temporary crown the tooth, "had very little clinical height" and that, "I was quite surprised there was a very small amount of composite in the mesiolingual area of the tooth"¹⁶ and that he was, "reasonably certain that a pulp exposure was present."
- He also said that the temporary crown was, "extremely thin" and that, "the over contouring was particularly evident in the lingual or tongue side of the tooth and was irritating the gingival tissues."¹⁷ He said that because of the lack of quality of the temporary crown that he decided to replace it and to allow the tissues to settle. He also significantly stated that tooth 46 was substantially cut by Dr Exler and would, "now require restoration." He emphasised the point, "I must say I'd never seen a gouge as big as that before."¹⁸
21. He said that he also believed that the pulp material was exposed under the temporary crown. He also made other criticisms of the temporary crown as indicated in his written report and that he would not have been preparing a permanent crown based on what he observed. He stated by way of conclusion that the opinion that he reached on 9 February was that, "the most predictable outcome would be to perform endodontic therapy first and then place the crown."¹⁹
22. During the course of cross-examination Dr Gliddon agreed he did not contact Dr Exler at any stage in order to confirm whether the nerve had been exposed by the crack in the tooth. He conceded on the issue of pulp exposure that he may have exposed the tooth in taking the composite material away but he added, "but I believe it not to be the case that I exposed it."²⁰ He was asked if he believed that the patient understood that Dr Exler was not committed to fixing a permanent crown and he said that it was his understanding a permanent crown was to be fitted. He said during re-examination when asked to comment on X-rays, "I would not be prepared to crown a tooth that looked like that" although he agreed that, "you cannot see pulp exposure on X-ray" and that Dr Exler did not adopt, "a reasonable approach" to the treatment of the fractured tooth because, "the health of the tooth should be treated before other considerations like function or

¹² Transcript p.22

¹³ Transcript pp. 23-24

¹⁴ Transcript p.27

¹⁵ Transcript p.34

¹⁶ Transcript p.35

¹⁷ Transcript p.36

¹⁸ Transcript p.37

¹⁹ Transcript p.38

²⁰ Transcript p.43

aesthetics."²¹ He said he was, "surprised" that Dr Exler would do a crown preparation at an emergency visit. He then added, "I have never experienced that or heard of it before."²²

23. The second allegation made against Dr Exler was made by Patient B (hereinafter referred to as Dr BB) by a notification dated 6 April 2007. She said she first attended Dr Exler's practice in Brighton on 10 February 2007 and she had a professional clean of all teeth as well as a fluoride treatment. She stated during the consultation that Dr Exler pressed her in to having her teeth whitened and two old silver fillings replaced. She therefore attended Dr Exler again on 24 February 2007. During this visit Dr Exler removed one of the fillings and replaced it with a white one. She said he persuaded her in having her teeth whitened as she had private health insurance. She had been initially advised she would be, "out of pocket" to the extent of \$50 and this was later amended to \$100. She was also told to make another appointment and she said she was, "Shocked when the bill totalling \$400 was presented to me of which I received \$200 back."²³
24. She said by 25 February 2007 she was still experiencing pain in the tooth that had been filled and by 26 February she was experiencing pain in the tooth whilst eating. She then attended another dentist who advised her that the filling was satisfactory but the teeth cleaning process had not been carried out satisfactorily. As a result of her visit to the other dentist she decided to return to Dr Exler.
25. On 26 February 2007 she attended at Dr Exler's surgery at approximately 6 pm. She did not have an appointment but she attended at his clinic as she was still experiencing pain in her tooth. She was told by the receptionist that she had to make an appointment for another consultation or put her complaint in writing.
26. She said she waited until the dentist could see her between patients and when he did speak to her he said that a fish bone may have been accidentally near the filling to cause the pain and when she said she had not eaten any fish recently she was informed by Dr Exler that, "It could be psychosomatic"²⁴ and he advised her to make another appointment, "Just in case".
27. She also stated that when she observed from her account that an Item 213 was included for the treatment of, "Acute perio infection" she told Dr Exler she was concerned that she had not been told she had an infection and the dentist responded that she did not have one and her teeth, "Were very good." Her subsequent statement she made to the Board Investigating Officer contained a repeat of those allegations and she added that notwithstanding that Dr Exler, "had full knowledge of the clerical error did not offer to correct it."²⁵
28. The Board received a letter from Dr Birdseye the dentist who Dr BB consulted after seeing Dr Exler and with respect to the account submitted by Dr Exler to the patient he stated, "Dr Exler was probably trying to maximise her insurance claim and thus minimise her out-of-pocket expenses."²⁶
29. The Board wrote to Dr Exler in relation to the complaints of this complainant on 13 April, 15 May and 30 May 2007 and Dr Exler replied on 10 June 2007. He stated "If Dr BB felt 'pressure' to undertake teeth whitening, I apologise as this was misunderstood. This could have occurred due to my over enthusiastic case presentation." In relation to the charge for the, "Acute perio infection" he stated, "I believe that a clerical error occurred as the correction of Item 111 in the records wasn't very clear and receptionist printed invoice with item 213."²⁷
30. He also made an explanation in relation to the formulation of the account concerning the filling to tooth 26 which he explained, "This filling consisted of

²¹ Transcript p.48

²² Transcript p.49

²³ Exhibit E at page 116 – Book of Evidence

²⁴ Exhibit E at page 115 – Book of Evidence

²⁵ Exhibit E at page 143 – Book of Evidence

²⁶ Exhibit E at page 145 – Book of Evidence

²⁷ Exhibit E at page 133 – Book of Evidence

composite materials of four levels. It led to a clerical error and four levels were described as four surfaces."

He disputed that the dental work he provided to Dr BB was of poor quality and that the account for \$400 dated 24 February 2007 was, "A moderate amount to pay for several procedures carried out: consultation, composite restoration, bleaching trays, teeth whitening and removal of plaque."²⁸

31. In his affidavit he also explained his fee charges and agreed that, "Clerical errors" were made. He said he admitted the clerical error in relation to the infection item to the complainant during a discussion he had with her on 24 February 2007, and that he had not amended or withdrawn the account. He denied his account in relation to the, "The removal of calculus" was false or that his work was sub-standard.
32. He also denied that he had behaved in an offensive manner when Dr BB visited him on 26 February 2007 and that he was placed in, "A difficult situation" as he and the patient were at the reception desk and that he wanted to communicate with her that there, "Could be a number of explanations for her discomfort."²⁹
33. When giving evidence to the Panel Dr BB stated that Dr Exler did not do any bleaching of her teeth and that in relation to the mistake with the account concerning the infection he stated, "I was told as I have put in my statement, that that would increase the amount of money that I could get back and that's why it was put on the item list."³⁰ In other respects she gave evidence consistent with her statements to the Board.
34. The third notification was from Mrs GG. She stated in her notification received by the Board on 21 March 2007 that she consulted Dr Exler on 19 February 2007 as she had chipped a small part of her front tooth and she wanted it restored. She stated Dr Exler suggested she have it filled to which she agreed. She also suggested that he fill another tooth to which he agreed.
35. Mrs GG went on to state that on completion of both fillings Dr Exler asked her to look in the mirror, and after doing so she decided she was not happy with the final result as the teeth, "Were not straight at the bottom, they were on a slight inward angle."³¹ She asked him to make them, "Horizontally straight" which he proceeded to do. She said the bill was then increased to \$600 which was, "Substantially more than he initially quoted during the procedure". She said she had paid \$200 and, "The remainder was left over."
36. She said she later concluded that, "The total price was absurd and he had also charged me for services he had not provided." She said a week after the appointment she noticed, "A small, sharp chip in my front tooth where a filling had been placed by Dr Exler" which distressed her and she concluded that Dr Exler had charged her for services he had not provided.
37. Dr Exler responded to those allegations by letter dated 11 May 2007 in which he stated that he saw Mrs GG on 19 February 2007 in his Brighton clinic and that she wanted teeth restored. He took X-rays which revealed possible decay of teeth 36, 46 and 16. He observed that whilst Mrs GG in her notification stated that he advised one filling was to cost \$150 and the other \$200 he recorded his fee of \$200 to \$300 for each tooth. He said there was obviously a misunderstanding between the parties on this issue for which he said he accepted the major responsibility. In any event he said he would reduce the account if the patient was not happy with it.
38. Dr Exler went on to state that the process took him three to four times longer than he anticipated and that the patient was not initially happy with the restoration and wanted the teeth to be, "Horizontally straight" and that he, "Had to build up both

²⁸ Exhibit E at page 134 – Book of Evidence

²⁹ Exhibit G at page 206 – Book of Evidence

³⁰ Transcript p.60

³¹ Exhibit F at page 155 – Book of Evidence

teeth to make them a little longer to create (the) desired horizontal line". He went on to state, "I remember putting many times composite material and restoration were engaging buccal occlusal mesial and palatal aspects of the teeth but still relatively small, so Items 522 or 523 probably more appropriate."³²

He said that finally the patient was happy with the result. He said he did not examine the patient after the filling chipped.

39. In her response Mrs GG said treatment of her teeth in fact made them worse and she stated that she wanted a refund of the sum of \$200 she paid him, and that she had to, "Pay another dentist to repair what he ruined."³³
40. A report was provided to the Board by Dr J Graham after the patient phoned his rooms on 1 March 2007 requesting emergency treatment for two lost fillings. He stated on examination shortly thereafter, "two defects were noted on the mesio-incisal aspects of both central incisors, with no evidence of other restorations in them."³⁴ He considered that as Mrs GG was a part-time model it would be best if he referred her to a prosthodontist, a Dr Stewart Cottis. In terms of Dr Exler's charges he said he would have charged her under Item 521.
41. Dr Cottis in a report to him stated he believed that the cause of the failure of the fillings, "can be isolated to a parafunctional habit nocturnally" and that 11 and 21 are, "particularly susceptible considering the deep over-bite" which he ultimately restored.
42. Dr Cottis also provided a report to the Board on 29 May 2007 and he said he discussed with Mrs GG his findings with respect to the parafunctional habit (grinding or bruxism) and their influence on the restoration process which he said was, "a common issue missed in restorative failure". He stated, "I did not see the treatment as sub-standard, but merely that the issue of bruxism had been missed."³⁵
43. In his affidavit Dr Exler stated he was uncomfortable about lengthening the patient's teeth because it was not clinically indicated, "but I made the mistake of endeavouring to meet Mrs GG's wishes in this regard"³⁶ and that because she was a, "grinder this may have increased the risk somewhat." He stated that he believed his charges for the work he did for her were reasonable and that he conceded that he did not provide Mrs GG with information in relation to, "Treatment options, likely outcomes, advantages, disadvantages, risks and possible complications related to bruxism."³⁷
44. When Mrs GG gave evidence she had no recall of any discussion on the subject of bruxism. During cross-examination she said she wanted her teeth horizontally straight. She said she was not aware that she grinded her teeth at night.
45. The Board's Investigating Officer Dr Roseman gave evidence and made a written statement and stated that in his opinion a number of the charges administered by Dr Exler were inappropriate and charges were made against the wrong items. He expanded on those matters when giving evidence and stated that the Australian Schedule of Dental Services Glossary 8th Edition provided, "the definitive coding system for dental treatment"³⁸ and that the health funds, "basically require an itemised account, and they use the item number which is assigned to the procedure to identify the rebate they pay"³⁹ and that if an incorrect item number is described an incorrect rebate will result.
46. He also gave evidence that the Board's Infection Control Procedures relating to the use of gloves, masks and gowns which were required to be worn at all times

³² Exhibit F at page 167 – Book of Evidence

³³ Exhibit F at page 174 – Book of Evidence

³⁴ Exhibit F at page 176 – Book of Evidence

³⁵ Exhibit F at page 186 – Book of Evidence

³⁶ Exhibit G at page 208 – Book of Evidence

³⁷ Exhibit G at page 209 – Book of Evidence

³⁸ Transcript p.93

³⁹ Transcript p.104

and he referred to the guidelines in relation to Infection Control in the Health Care Setting.⁴⁰ He said that Dr Exler's admission that he was not wearing a gown at the time of treating Mr NN meant that he failed to comply with those guidelines notwithstanding the conflict in the evidence between the patient and Dr Exler as to what he was wearing at that time.

47. He was asked a number of questions in relation to the charges made by Dr Exler. He stated that in some instances, especially in relation to the Item 521 charge, he could recover a higher rebate than in relation to the item that he should have used.
48. In the course of cross-examination Dr Roseman stated that at law a dentist may charge whatever he likes but the itemisation is important in relation to rebates and that, "Common sense" needs to be applied in determining whether a dentist, "Has done the wrong thing in invoking a particular number in the ADA schedule" which he conceded was a matter for the Panel to determine.
49. Dr Exler chose not to give evidence.
50. In his affidavit Dr Exler stated that he admitted, "That I failed for a considerable and unreasonable time to respond to Dr Roseman's requests" in relation to the complaints made by the three notifiers. He stated that he had been in difficulty with the Board before and that, "I did not know what to do or where to turn and put my head in the sand." He further stated that as a consequence of all that has occurred to him, "and the demoralisation that ensued, I have allowed my registration to lapse while I gather my equanimity and readiness to return to practice in due course."⁴¹

Analysis of the Evidence and the Panel's Findings.

51. Dr Exler has admitted that he has engaged in unprofessional conduct of a serious nature in failing to respond to Dr Roseman's requests and to respond to the notifiers' complaints.
52. In analysing the written and oral evidence provided by the three complainants and the expert dental witnesses the Panel finds that all witnesses were attempting to provide an accurate and reliable account to the Panel of relevant events and that the reports of the doctors who treated the various patients constituted an accurate and helpful response in relation to the professional opinions expressed and the history provided. As the Panel did not hear evidence from Dr Exler from the witness box, and in the light of the above findings, where there is a conflict in the evidence between the complainants and the expert dental witnesses and Dr Exler, the Panel will give preference to the evidence and statements of those witnesses. The Panel is of the opinion that in terms of its fact finding responses, that it was considerably disadvantaged by Dr Exler's decision not to give evidence.
53. In relation to the first notifier, Mr NN, the Panel accepts his evidence and further accepts that Dr Exler provided treatment to tooth 46 of the patient, the tooth having been reported to have been fractured earlier that evening. The patient was in pain and distress at the time he attended Dr Exler's surgery and the Panel accepts that during the course of an extremely long consultation which the patient found highly distressing Dr Exler removed the broken part of the tooth, placed a filling to cover the damage to the tooth, placed a temporary crown on the tooth and took an impression for a permanent crown. Dr Exler also cut part of an adjoining tooth, namely tooth 47 in the process.
54. This patient alleged that Dr Exler's pain management was poor, in that he administered anaesthetics that were ineffective, he was not satisfied with the treatment performed and that the charges were excessive and that his Infection Control procedures were poor in that Dr Exler did not wear a mask and gloves. As a result of all these matters he obtained an opinion from Dr Gliddon and the Panel accepts his evidence and the opinion expressed by Dr Gliddon as set out above.

⁴⁰ Exhibit C at page 68 – Book of Evidence

⁴¹ Exhibit G at page 210 – Book of Evidence

The Panel also accepts Dr Gliddon's opinion that there was, "Little evidence of restoration/core material in the ML region."⁴²

55. Having accepted the evidence of Dr Gliddon the Panel is of the opinion that the manner in which Dr Exler's treatment of Mr NN was well below the standard that would be expected of a member of the public and Dr Exler's peers for the following reasons:
- Firstly the Panel believes it was inappropriate in an emergency context to provide a temporary crown in the circumstances and that the fitting of a temporary or permanent filling would have been more appropriate. In the Panel's opinion, a crown was the last option of choice that should have been contemplated by Dr Exler.
56. The Panel also prefers the evidence of the patient on the issue of Infection Control. The Panel accepts the evidence of both the patient and Dr Gliddon that the patient was distressed and traumatised as a result of the treatment that was provided to him by Dr Exler on this occasion, and in addition he was financially and dentally disadvantaged in all the circumstances. The Panel believes that the manner and method of treatment constitutes unprofessional conduct of a serious nature in accordance with the definitions of that term contained in Paragraph (a) and (b) of s.3 of the Act. The Panel finds all of the allegations in the Notice of Hearing in relation to this patient Mr NN, namely paragraphs G to J, Paragraphs K to N inclusive and O to T inclusive proven, save in terms of the categorisation it was grossly sub-standard. In the Panel's opinion it was significantly sub-standard.
57. The second group of allegations relate to the patient Dr BB. She was treated by Dr Exler on 10 and 24 February 2007 at his Brighton rooms for an oral examination and a professional clean of all her teeth as well as fluoride treatment. Her concerns arose when she received an account from Dr Exler which included a charge for the treatment of an infection. The evidence provided on this issue satisfies the Panel that this charge was false and without justification.
58. She also complained about being pressured into having her teeth whitened. She made a further complaint about the manner in which she was treated when she attended Dr Exler's surgery on 26 February 2007, as a result of being in pain. In the Panel's opinion, the most significant matter established in relation to Dr Exler's dealing with this patient relates to the manner in which his charges were calculated, particularly in relation to the inaccurate itemisation of procedures, and the subsequent claiming entitlements.
59. The Panel is not persuaded by Dr Exler's explanations in this regard. In terms of the manner in which Dr Exler related to the patient when she attended on 26 February 2007, the Panel notes whilst he conceded his dealings with the patient were insensitive and inappropriate, particularly in relation to suggesting that her pain was psychosomatic, the Panel is of the view in the overall context in which the patient presented, namely that she did not have an appointment, she spoke to Dr Exler in an informal context, that on this particular aspect of his treatment and dealings with the patient, it did not constitute unprofessional conduct.
60. However, in respect of the other matters referred to in the Notice of Hearing, namely with regard to the charge administered and the method of charging, the Panel is satisfied that this conduct constitutes unprofessional conduct, but not of a serious nature as it could not be categorised as constituting a gross departure from acceptable standards of behaviour viewed from the perspective of Dr Exler's peers and members of the public.
61. The third group of complaints related to the treatment of the patient Mrs GG who was treated at his Brighton clinic on 19 February 2007. These complaints related to sub-standard dental work in connection to two fillings applied in relation to teeth 11 and 21 which fell out within days of treatment, and with respect to the quotation in respect of his fees in that she was initially quoted \$150 per filling, that is \$300 in

⁴² Exhibit D at page 104 – Book of Evidence

total and she received an account for \$600.

62. The evidence revealed that in all probability the patient suffered from bruxism, and this was not taken in to account by Dr Exler in terms of the overall treatment of the patient, particularly in relation to the impact that bruxism posed with regard to the manner in which her dental care should have been conducted. Dr Exler conceded in some respects his treatment of this patient was less than ideal although the Panel notes that Dr Cottis said it was not, "sub-standard". In the Panel's opinion the most significant shortcoming in terms of this patient, is the failure by Dr Exler to properly diagnose bruxism, and in the inadequacies of the management of this patient in terms of the risks that bruxism imposed.
63. The Panel is also concerned with the use of the item codes in this particular situation. However whilst the Panel is satisfied that Dr Exler's conduct towards this patient was less than ideal, it is not satisfied after considering the evidence provided that his conduct towards the patient falls within the categorisation of unprofessional conduct as set out in the Act.
64. In terms of assessing the overall nature of Dr Exler's method of charging patients and record keeping, the Panel is of the opinion that his failings in this regard are quite significant, and the Panel is most anxious that he obtain his patients' full consent to all forms of treatment he administers and in respect of the charges that he proposes to make, and that he ensures serious errors are not made in itemising accounts which has occurred in his dealings with the second and third complainants.
65. In terms of the final group of allegations contained in the notice, that is Dr Exler's failure to respond to the letters which Dr Roseman forwarded to him in regard to all three patients, the Panel simply notes that Dr Freckelton SC has already conceded, on behalf of his client, that Dr Exler's failure to respond to the letters that were forwarded to him on behalf of the Board constitutes unprofessional conduct of a serious nature.
66. In summary, in relation to the various allegations contained in the Notice of Hearing, the Panel notes with regard to Patient G the Panel finds unprofessional conduct of a serious nature in accordance with the definition of that term contained in Paragraphs (a) and (b) of the Act.
67. In relation to Dr BB the Panel finds unprofessional conduct not of a serious nature. In relation to Patient Mrs GG, whilst the conduct was less than ideal, the Panel is not satisfied the conduct established constitutes unprofessional conduct as defined in the Act. In relation to the failure to respond to the letters forwarded by the Board to Dr Exler, the Panel finds unprofessional conduct of a serious nature in accordance with Paragraphs (a) and (b) of the definition of that term contained in the Act.
68. The Panel has considered whether it should categorise Dr Exler's conduct as falling within the term, "Professional misconduct" a term which requires establishment of a major departure from the standard expected of a dental practitioner. After considering the evidence the Panel does not believe this has occurred. In other words whilst the Panel is persuaded that it should categorise Dr Exler's professional conduct as inefficient or careless or negligent, it would not categorise it as grossly negligent or falling within the analysis of this term as set out in the decision *Pillai v. Messiter (No.2) 1989 16 NSW LR197*. In that case the court stated, (see the judgment of Mr Justice Kirby) in terms of proving professional misconduct:

"Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."⁴³

⁴³ *Pillai v. Messiter (No.2) 1989 16 NSW LR197*

69. The Panel after announcing the above findings then heard submissions from both counsel as to the determinations that the Panel should make. Mr Monahan, assisting the Panel indicated that Dr Exler was, "One of the most significant repeat offenders that have been dealt with by the Board and its predecessor."⁴⁴ In this regard Mr Monahan stated that Dr Exler had been the subject of a number of disciplinary proceedings that were set out in detail in the judgment of Dove J which was delivered on 8 December 2005.
70. A summary of these matters is as follows:
- (a) On 4 December 1996 Dr Exler was convicted of a breach of the Commonwealth Financial Transactions Act (which Mr Monahan described involving offences related to the subject of money laundering) and later appeared before the Dental Board. The Board determined that Dr Exler's name be removed from the Register of Dental Practitioners for a period of two months. In July 1997 Dr Exler was found guilty of what His Honour described as false advertising and fined \$6000. He also received a reprimand and had a condition imposed on his right to practice in relation to advertising.
 - (b) In September 2001 a Panel appointed under the Act found Dr Exler guilty of a number of charges in relation to providing treatment to a patient without her prior consent and that he failed to advise the patient he was not recognised as a provider by HBA. He was fined a total of \$34,000 in relation to finding of professional misconduct and unprofessional conduct of a serious nature. He was also suspended from dental practice for a period of three months. He also received a reprimand and caution.
 - (c) In the matter before Judge Dove, allegations were made against Dr Exler in relation to his treatment of six patients and as a result he was fined a total of \$17,500 and his registration was suspended for a total of 180 days.
71. At Paragraph 38 of His Honour's judgment he administered a lengthy reprimand and caution of a most serious nature which included the following:
- "The seriousness of the matters which have come before the Board on this occasion have been compounded by your history, your repetition of conduct and your willingness to avoid the consequences of your actions by whatever means. These factors compel this Panel to the view that you will again repeat your mistakes unless the determinations which are imposed by this Panel deter you from such future conduct."⁴⁵
72. In the light of Dr Exler's history Mr Monahan submitted that if taken in isolation the findings against Dr Exler, "Would be seen to be of moderate seriousness" but in view of Dr Exler's history, "The Panel might perceive them to be of much greater seriousness"⁴⁶ because repeat issues were involved in relation to Infection Control, failing to respond to the Board's letters and the informed consent together with likelihood of repeat behaviour. Mr Monahan went on to say, "So one just has to conclude that there is a very significant risk that if he returns to practice as he fully intends to do, Dr Exler will again imperil the public of Victoria in one or other of the many ways in which he has regularly offended in the past."⁴⁷

⁴⁴ Transcript p.222

⁴⁵ Exler v DPBV [2005] VCAT 2595

⁴⁶ Transcript p.231

⁴⁷ Transcript p.232

73. Mr Monahan also drew the Panel's attention to the fact that Dr Exler is not a registered dental practitioner at present and therefore, "He has no registration currently for the Panel to suspend."⁴⁸ In these circumstances he submitted that the Panel should impose a substantial fine on Dr Exler and that Dr Exler undergoes counselling and that conditions be imposed on his right to practice when he is authorised to do so.

74. Dr Freckelton SC in response included the following statement which has been carefully considered by the Panel in the determinations it has made:

"Dr Exler, contrary to what you might at first think, has been very significantly affected by the complaints in this regard and it was in that context that he decided not to apply for further registration. Dr Exler in fact is a distressed and troubled man who is not currently working in any context and who feels acutely the stigma for himself and for his children of another adverse finding by this Board. He is not a flagrant violator of determinations from this Board and from VCAT. He has made a number of mistakes in the past but feels acutely any criticism of his provision of therapeutic services."⁴⁹

75. Dr Freckelton SC went on to state that the delays in the responses to the Board were not substantial and that he attended to the various letters within two months, and that as a result the Panel's response to these matters should be, "A measured one" (T p.241). In relation to the errors of judgment he said that they were not to his benefit commercially and he categorised them, "As an inappropriate error of judgment by a practitioner in good faith" (T p.242).

76. He concluded by stating that if fines were to be imposed they should not be imposed in a punitive or retributive sense and that any penalty imposed must be strictly related to the conduct of Dr Exler.

77. In response to a question by Mr Monahan Dr Exler provided an undertaking to the Panel in the following terms:

"I undertake that I will not apply for registration as a dentist in Victoria at any date before 1 January 2010."

Dr Exler formally stated to the Panel that he unreservedly gave that undertaking. The Panel regarded this undertaking as a very significant matter in formulating the determinations hereunder. Further submissions were made by Dr Freckelton SC in relation to further education, counselling and the conditions under which Dr Exler should be permitted to return to practice when he was able to do so.

Determinations

78. The Panel then made the following determinations. Pursuant to the provisions of s.47(2) of the *Dental Practice Act 1999*.

1. Pursuant to sub-paragraph (a) that Dr Exler undergo both lectures and hands-on courses in the area of prosthodontists including treatment planning, endodontics, management of cracked cusps and Infection Control and that these courses are to be completed within six months of Dr Exler obtaining re-registration. These courses are to be approved by the Board and to be at Dr Exler's expense.
2. In accordance with sub-paragraph (b) of the Act that Dr Exler is specifically cautioned in relation to obtaining informed consent from his patients, both in terms of the treatment to be provided and the method of treatment and the fees to be charged and the method of communication with patients.
3. In accordance with sub-paragraph (c) that Dr Exler is formally

⁴⁸ Transcript p.235

⁴⁹ Transcript p.239

reprimanded for his failure to exercise proper clinical judgment in relation to this treatment of Mr NN.

4. In accordance with sub-paragraph (e) the Panel imposes the following conditions on Dr Exler in the event that he is re-registers, namely that he undertake and participate in courses in relation to record keeping and obtaining informed consent from his patients, those courses to be approved by the Board and to be undertaken at Dr Exler's expense and that the courses be undertaken within six months of his obtaining re-registration. Further Dr Exler is to permit the Board to undertake a random audit at all five locations of his practice within a period of 12 months immediately following obtaining re-registration.
5. That in accordance with sub-paragraph (f) of s.47(2) that the Panel imposes a fine of \$5000 on Dr Exler with respect to his failure to respond to the letters received from the Board and a further fine of \$5000 for his failure to comply with the professional requirements expected of him in relation to his dealings with the patient Mr NN.

**Peter Hardham
Chair
15 April 2009**