

# THE DENTAL PRACTICE BOARD OF VICTORIA

## Dr Alex Fibishenko [2008] DPBV 1

**Panel:** Mr Michael Gorton (Chair)  
Dr Gerard Condon  
Dr Mandy Leveratt

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

**Counsel for the Practitioner:** Dr I Freckelton instructed by DLA Phillips Fox, Lawyers

**Dates of Hearing:** 1 - 2 August 2007, 5, 6, 11, 12 September 2007 & 9 November

**Date of Decision:** 11 February 2008

### **FINDINGS**

The Panel, having considered the evidence and submissions placed before it, finds the following allegations in the Notice of Formal Hearing under section 45 of the *Dental Practice Act 1999* ("the Act") dated 19 July 2007 ("the Notice") to be established:

1. At all relevant times Dr Fibishenko was registered as a dental care provider in Victoria under the *Dental Practice Act 1999* ("the Act").

#### **Allegation (b)**

2. During the period from June 2002 to January 2003 Dr Fibishenko provided highly complex dental treatment to patient Ms AB.

#### **Allegation (d)**

3. The treatment was as described in paragraph (d) of the Notice.

#### **Allegation (e)**

4. The treatment provided was more complex than Dr Fibishenko's training and experience at that time would properly allow.

#### **Allegation (h)**

5. Dr Fibishenko recommended and commenced a treatment plan that was highly complex in its concept.

#### **Allegation (j) (ii)**

6. Dr Fibishenko failed to inform Ms AB that the treatment plan was beyond his training and expertise at that time and therefore failed to obtain fully informed consent to the proposed dental treatment. In other respects the Panel concedes Ms AB was adequately informed.

The Panel finds on the evidence and pursuant to section 47(1)(a) of the Act that Dr Fibishenko has engaged in unprofessional conduct of a serious nature.

The Panel is not persuaded that the other specific allegations are made out, in particular those allegations relating to specialists. It was not, in the end, the Board's case that specialist treatment was required.

## **DETERMINATIONS**

The Panel pursuant to section 47(2) of the Act makes the following determinations:

1. That Dr Fibishenko is reprimanded for his unprofessional conduct of a serious nature.
2. That Dr Fibishenko is cautioned against any repetition of his unprofessional conduct.

## REASONS

1.1. The Findings arose from a Notice of Formal Hearing dated 19 July 2007 which alleged as follows:

- (a) At various relevant times, you have been registered as a dental care provider in Victoria under the *Dental Practice Act 1999* ("the Act").

### A. Introduction – The Patient

- (b) During the period from August 2002 until April 2003, you provided highly complex dental treatment to a patient named Ms AB;
- (c) A copy of your patient card recording the details which you maintained of such treatment is **attached**.

### B. The Treatment

- (d) In the course of providing such dental treatment, you placed seven "STERIOSS" implants in Ms AB's maxilla at 12, 22, 13, 23, 15, 17 and 26 utilising bilateral sinus floor grafts of a combination of a bovine bone xenograft (BIO-OSS) and autogenous bone. The upper anterior ridge was augmented utilising particulate autogenous bone and bovine xenograft (BIO-OSS) stabilised with titanium mesh. You also placed an upper flangeless denture rigidly fixed to the mid-palate with three titanium fixture screws;
- (e) The dental treatment which you provided to Ms AB was more complex than your training and experience would properly allow and, in the circumstances, you should not have undertaken that dental treatment;
- (f) You failed to refer your patient to appropriate specialists before commencing treatment and implementing your treatment plan, in circumstances where it was necessary and appropriate for you to do so
- (g) This procedure was a high risk procedure with limited prospects of success;
- (h) You recommended, commenced and implemented a treatment plan which was extremely complex in its concept, deficient in planning and had limited prospects of success.

### C. Consent

- (i) Prior to commencing the treatment, you failed to provide Ms AB with all necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed;
- (j) In particular, you failed to inform Ms AB that:
- (i) this procedure was a high risk procedure with limited prospects of success;

- (ii) you lacked formal training;
- (iii) she would be much better off in the hands of an appropriate specialist.
- (k) You accordingly failed to ensure that your patient understood what treatment she was consenting to, and had the necessary details and information available to her concerning such treatment before she provided any apparent consent;
- (l) You accordingly failed to obtain the prior consent (fully and appropriately informed) of Ms AB to that dental treatment being performed.

**D. Conclusion**

- (m) Accordingly, in providing these dental services to your patient, you engaged in unprofessional conduct as defined in Section 3 of the Act;
- (n) Such unprofessional conduct was of a serious nature.

1.2. The Panel heard evidence from Dr Stephen Chen, periodontist, Associate Professor Andrew Smith, oral and maxillofacial surgeon, the informant Ms AB, Dr Anthony Roseman and Drs Giblin and Collins called on behalf of Dr Fibishenko.

1.3. The treatment given to Ms AB is concisely stated in paragraph B(d) of the Notice, but although concisely stated there it gave rise to a very great volume of evidence. In opening the case to the Panel Counsel Assisting said: 'Perhaps the key allegation in the whole case is paragraph (e) where we say the dental treatment which Dr Fibishenko provided to Ms AB was more complex than his training and experience would properly allow and he shouldn't have done it'.

'We say he hadn't had sufficient mentored clinical surgical experience to take on a case like this'.<sup>1</sup>

Counsel Assisting also emphasised that this case was not a demarcation dispute between specialist and general dentists. It is a case that focuses on Dr Fibishenko's level of training and experience at the time he treated this patient.

The Panel observes that on its face, the Notice in paragraphs (f) and (j)(iii) specifically refers to specialists and can understand why it was thought to raise a demarcation dispute.

## Evidence re Ms AB

2.1 The evidence of Ms AB was by way of transcript which recorded her evidence in an earlier (subsequently discontinued) hearing. Both Counsel Assisting and Counsel for the practitioner agreed that the matter should proceed on this basis.

2.2 The transcript reveals that Ms AB had dental treatment performed by Dr Fibishenko commencing in June 2002. Ms AB said she was looking for a dentist who worked in implant dentistry, and discovered Dr Fibishenko on a web site. Ms AB explained that she had felt vulnerable on a fishing boat trip – “was really very badly seasick and felt if I had lost the denture I’d be in a fairly bad place”. That really was what started her thinking of having a dental appliance that could not be removed by herself.

2.3 More will be said later in these reasons about what Ms AB was or was not told about the procedure proposed, and the risks associated with it, when the allegation of failing to obtain informed consent is dealt with.

The case as opened by Counsel Assisting was not so much concerned with the ‘risks’ associated with the procedure proposed, per se, but rather that Dr Fibishenko’s training and experience at that time did not fit him to deal adequately with those risks, and that therefore he should not have undertaken the treatment.

2.4 On 23 July 2002 a letter was sent to Ms AB stating that the treatment plan had been finalised with surgery on 6 August 2002. The proposed procedure was as follows:

- “Placement of up to 10 titanium implants in upper and lower jaws
- Left and right sinus lift procedures
- Bone augmentation as necessary using titanium mesh and Bio-Oss
- Bone harvesting (only if necessary) from inside of chin
- Insertion of gold-based denture fixed with titanium screws into the palate.”

2.5 It was noted in the letter that the extent of the procedures is guided by prevailing circumstances during the surgery and the quality of the underlying<sup>2</sup> bone.

The plan also noted that it may require that grafting only be performed and that implant placement be delayed.

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<sup>1</sup> Transcript p 28

<sup>2</sup> Book of Evidence p 134 et seq

Of this plan Dr Chen, referred to in 3.1 et seq, below, said it was appropriate but it should have been staged and different aspects of it should have been done by appropriately qualified and specialised people.<sup>3</sup>

2.6 Dr Fibishenko has reported the surgery as follows:

“Following a sterile surgical protocol local anaesthetic/analgesic (Marcaine) was administered by infiltration and bilateral posterior-superior alveolar blocks. The following procedures were performed in order:

Crestal incision with posterior relieving incisions.

Full arch buccal & labial muco-periosteal flap retraction.

Full arch palatal muco-periosteal flap retraction. Retraction was initially maintained with retractors, then sutures.

The alveolar bone was inspected and cleared from periosteal residues and scored using hand instruments only.

The operating field was clear. The angulation of bone and presence of an anatomical labial concavity was perhaps slightly worse than expected (due to a thick mucosa) but not unfavourable for implant placement.

The pneumatized sections of the sinuses were easily identifiable due to thin lateral sinus walls.

The right sinus window was demarcated and lifted using only manual instruments. The membrane at the sinus floor was somewhat thicker than normal and was not perforated. The sub-antral space was inspected and was smooth and even (as expected). The sub-antral bony surface was roughened using manual instruments.

The anaesthetist (Dr Robert Watson) had drawn a small amount of blood that was placed in a dish containing the bio-oss graft material. He also administered Amoxicillin 1g IM. Some bio-oss was placed in the sub-antral space in order to keep the sinus membrane retracted.

A round bur was used to define the lateral window for the left sinus lift procedure. The membrane was gently elevated. The sub-antral space was more constrained. The bone surface was roughened using manual instruments and Bio-oss was placed in the sub-antral space.

The surgery was progressing well and ahead of the estimated time.

The surgical stent was fitted and rigidly fixed to the palate with only two fixation screws.

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<sup>3</sup> Transcript p 136

The surgical stent was fitted and rigidly fixed to the palate with only two fixation screws.

The palatal muco-periosteal flap was cross-sutured for retraction.

Implant osteotomies were performed in the following order: 12, 22, 23 and 13. Twist drills (using both internal and external irrigation) were used in an alternating fashion with manual osteotome expansion.

The density/quality of the bone was generally fair. Positioning dimples were placed in the posterior maxilla prior to removal of the surgical stent.

The surgical stent was then removed and the palatal mucosa again cross-sutured for retraction. The fixtures were manually inserted causing only an insignificant crestal fracture distal to the 13 fixture. All the anterior fixtures achieved excellent primary stability but some labial threads were exposed in 12 and 22 sites.

The particulate bone from the osteotomy process was carefully collected and placed in a separate dish containing a droplet of blood.

Additional bone was manually harvested laterally from the left poster maxilla/tuberosity.

The autogenous bone was added to the sub-antral spaces in the immediate sub-crestal vicinity where implants were planned.

The following fixtures were then inserted utilising a similar technique to that which was previously described: 15, 17 and 26. The manual osteotomes were also used to internally expand and elevate the bony sinus floor. The 15 was placed in poor bone and the apical portion of the fixture was visibly protruding into the sub-antral space but a reasonable primary stability had been achieved. The 17 was a flapless tissue punch procedure. It was also placed in generally poor bone but had good primary stability. A healing abutment was placed on the 17. The 26 was placed in fair bone and had good primary stability. A small apical portion was suspected to protrude into the sub-antral space. An additional fixture was attempted in the 25 site. Primary stability was not achieved and parts of the surrounding bone unfavourably fractured. The site was repaired with bio-oss. The titanium mesh was then cut and formed as planned pre-operatively. It was adjusted and adapted to the maxilla. The remaining particulate autogenous bone was placed labially followed by the bio-oss. The titanium mesh, extending approximately 14 to 24 sites, was then fixated to the 13 and 23 fixtures by utilising the cover screws and labially to the anterior nasal spine using 3 titanium fixation screws.

Excellent stability of the mesh was achieved.

A cut section of non-restorable membrane (Regentex) was then adapted over crest and palatally of the titanium mesh.

The bucco-labial flap was released and the tissues neatly and passively approximated for primary closure.

Primary closure was achieved using both mattress and interrupted suturing techniques with 3-0 Silk Sutures.

The mouth was well irrigated and there was no excessive bleeding or other complications.

The hollowed flangeless upper denture with a mid palatal gold plate was immersed in chlorhexidine then dried with clean sterile gauze. It was relined with 'Voco-pac' and seated into position with manipulation into closure of the opposing jaw. The denture was then successfully rigidly fixed to the mid-palate with 3 titanium fixation screws.

It was decided to postpone surgical treatment of the lower jaw in order to reduce post-operative discomfort".<sup>4</sup>

2.7 Dr Fibishenko reported about membrane removal at nine weeks post operation. He said:

"Ms AB presented with an exposure of the membrane in the mid-palatal maxillary ridge region. There was also some evidence of local infection and a suspicion that the infection could extend under the membrane.

"...the membrane was removed and the area irrigated and debrided. The spread of infection appeared to be limited".<sup>5</sup>

2.8 Dr Fibishenko has said of the treatment plan that it was a "complex treatment plan"<sup>6</sup> and "The nature of Ms AB's treatment is inherently complex not only in its planning and management but also in tissue response".<sup>7</sup>

2.9 It will be remembered that the Notice, in allegation B alleges a highly complex treatment plan which had limited prospects of success.

2.10 Dr Fibishenko queries the description "extremely" complex but said:

"The treatment was reasonably complex but I would not classify it as "highly complex". From my perspective, the execution of the treatment was not especially difficult but the treatment plan was sophisticated".<sup>8</sup>

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<sup>4</sup> Book of Evidence pp 159-160

<sup>5</sup> Book of Evidence p 162

<sup>6</sup> Book of Evidence p 150

<sup>7</sup> Book of Evidence p 151

<sup>8</sup> J1 - Affidavit – para 169 Evidence Book p 315

In response to a question from the Panel Dr Fibishenko said “that this was at the time probably the most complex case that I’ve done, but it wasn’t significantly more complex”.<sup>9</sup>

- 2.11 The Panel notes that Dr Fibishenko’s response to the allegations made has included two very long affidavits and a report on his treatment of Ms AB written up as a case study report. This ‘report’ was 27 pages long and attached 11 pages of references to various journals and articles concerning (inter alia) the use of Bio-oss.
- 2.12 The Panel considers that the ‘report’ encapsulates Dr Fibishenko’s responses to the allegations made of his treatment of Ms AB. Of note is the comment made by Dr Fibishenko that Ms AB was a ‘non-compliant’ patient.<sup>10</sup>
- 2.13 The Panel heard nothing to justify that comment.
- 2.14 The Panel also heard evidence about Dr Fibishenko’s experience at the time he undertook the treatment of Ms AB.
- 2.15 It should be clearly stated that the Panel is only concerned about his skill and training at the time in 2002.
- 2.16 The evidence disclosed that Dr Fibishenko had had considerable training of a didactic nature in implantology and use of Bio-oss. The Panel was more concerned about the extent of his practical experience and training. This becomes important because of the evidence of Dr Chen and Associate Professor Smith which is discussed below.
- 2.17 Dr Fibishenko supplied some details of his clinical experience prior to operating on Ms AB. Dr Fibishenko said that implant surgery could be classified as simple, of moderate complexity and complex. The data that Dr Fibishenko produced, he agreed, showed that he had only done five previous cases he would place in the complex category.<sup>11</sup>

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<sup>9</sup> Transcript 545

<sup>10</sup> Book of Evidence p 486

<sup>11</sup> Transcript 618

- 2.18 Prior to Ms AB Dr Fibishenko had performed five sinus lifts and had not previously put in a fixed upper denture screwed into place, or used titanium mesh. (Transcript p 440). The Panel also noted (Transcript p 613) that Dr Fibishenko had not used titanium mesh again since this one and only procedure as he had “not a bad experience but a bit of a setback with it”.
- 2.19 It was put to Dr Fibishenko in cross-examination that what he was planning to do with Ms AB was a major step upwards in complexity from anything he had done in the past. His response was that it was a ‘gradual’ step upwards – “the next step upwards as my clinical experience goes”.<sup>12</sup>
- 2.20 Dr Fibishenko said that the performance of five prior sinus lifts was adequate experience. Dr Chen, below, disagreed.
- 2.21 Dr Fibishenko finally agreed that:
- “I think I accept that in general terms being admittedly that the most complex case that I’ve treated...seeking a second opinion would have been reasonable”<sup>13</sup>.
- This, in the Panel’s opinion, was the only time in the proceeding when Dr Fibishenko showed any insight.
- 2.22 Throughout his evidence Dr Fibishenko insisted that he had sufficient experience and skill in 2002 to carry out the treatment on Ms AB, and that there was never any reason to refer Ms AB for a second opinion.
- 2.23 Throughout his evidence he continued to assert that Ms AB was a non-compliant patient – particularly with regard to her wearing of a denture, but also to her consumption of alcohol.
- 2.24 There was no good evidence before the Panel that Ms AB over indulged in alcohol – in fact her consumption seems to have been moderate – or that she was ‘non-compliant’.

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<sup>12</sup> Transcript 619, 620

<sup>13</sup> Transcript 736

- 2.25 Ms AB left the care of Dr Fibishenko in early January 2003 and obtained treatment elsewhere.
- 2.26 Dr Fibishenko graduated from the University of Melbourne in 1995. He became a registered dentist in Victoria in 1996 and practised as a general dentist in implant procedures and restorative dentistry.
- 2.27 In his first affidavit (some 50 pages in length plus exhibits) Dr Fibishenko outlines his experience between 1996 and 2002.<sup>14</sup> The Panel does not intend to examine all that material in depth in these reasons but it has taken account of what appears in the affidavit, the second affidavit, all the exhibits, and of course Dr Fibishenko's viva voce evidence.

### **Evidence of Dr Stephen Chen**

- 3.1 Dr Chen's CV shows that he graduated MDS from the University of Melbourne in 1986, and had previously graduated BDS from the University of Malaya in 1982.
- 3.2 Dr Chen practises as a periodontist and is a Fellow of the Royal Australasian College of Dental Surgeons. He holds appointments as external examiner at a number of seats of learning including Universities of Queensland, Sydney and Melbourne, among others. He holds hospital appointments as Senior Registrar Periodontics at Royal Dental Hospital Melbourne, House Officer at the hospital and at the Dental Implant Unit at Royal Children's Hospital Melbourne.
- 3.3 Dr Chen is registered as a specialist periodontist with the Dental Practice Board of Victoria from 1990 and continuing.
- 3.4 A list of Dr Chen's professional organisations is listed in the CV, as is a list of his publications, and other positions held.
- 3.5 In all, the Panel finds Dr Chen an eminent member of the dental profession here and overseas and eminently qualified to give expert evidence in this hearing.
- 3.6 The Panel has set out in some detail Dr Chen's qualifications because in his own evidence Dr Fibishenko appeared reluctant to acknowledge Dr Chen's eminence in the field of implantology.

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<sup>14</sup> Book of Evidence p 281 et seq

3.7 Associate Professor Smith, whose evidence is discussed below, said of Dr Chen:

“He has one of the highest reputations in – not just in the field of periodontics but also in implants both nationally and worldwide”.<sup>15</sup>

3.8 Dr Chen’s evidence was very lengthy and the difficulty is to decide how little can be referred to in those reasons.

3.9 In discussing didactic and clinical education he said this:

“You can do as much reading as you like and attend as many courses as you like, but if you don’t begin to provide treatment in a supervised manner or under the care or guidance of someone then you are never going to be able to develop the clinical skills. So clinical training is quite separate to didactic training but the two must go hand in hand”.

“ in acquiring new skills or developing new skills there is a responsibility from the clinician to ensure that at all times they practice within their clinical ability...”<sup>16</sup>

3.10 He said that “ it’s the responsibility of the clinician to ensure that their development in education and training and experience and exposure to clinical procedures is done in a stepwise and a gradual manner so it builds on their experience”.<sup>17</sup>

3.11 After considering the material presented to him in this matter, which was all the material provided by Dr Fibishenko, Dr Chen’s opinions were:

- Dr Fibishenko’s experience in 2002 with advance procedures was rudimentary<sup>18</sup>
- A log is the only way you can reliably go back for yourself or others to review the depth and breadth of the procedures that you have performed<sup>19</sup>

3.12 The Panel notes that Dr Fibishenko did not maintain a log. He did, however, produce a table which, he said, summarised his experience prior to 2002 and up to “close to the present”<sup>20</sup>. Dr Chen had seen this summary.

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<sup>15</sup> Transcript 232

<sup>16</sup> Transcript 108

<sup>17</sup> Transcript 108, 109

<sup>18</sup> Transcript 118

<sup>19</sup> Transcript 120

<sup>20</sup> Fibishenko Affidavit para 58 Book of Evidence p 293 et seq

3.13 Dr Chen states: “A complex procedure is a complex procedure; whether it’s complex or highly complex is semantics. If a clinician has a lot of experience with complex procedures, they seem easy, but they’re not, they remain complex procedures.

...if the clinician starts to believe that what they are doing is easy then I think there is a major problem because that person is not recognising the degree of difficulty and is, in fact, overconfident in their ability”.<sup>21</sup>

- The treatment plan was appropriate but it should have been staged and different components of it should have been done by appropriately qualified and specialised people.<sup>22</sup>
- The use of rigid titanium mesh is highly technique sensitive and it does require significant surgical skills – and has a high level of difficulty to do well”.<sup>23</sup>
- The general dentist must recognise where his or her limitations be, and if the case is beyond those limitations or if they are limited in their experience, that’s when they should be referring a patient.
- Implant surgery can be performed by any dentist who’s got the appropriate training and background and education.<sup>24</sup> It is not correct to say that implant surgery should only be performed by specialists.
- On a scale of 1 to 10 of complexity “I would be considering this at least nine out of ten. The safest course was to stage the treatment.

### **Evidence of Associate Professor Andrew Smith**

4.1 Dr Smith trained as a dentist in the UK, qualifying in 1977. He then trained in oral and maxillofacial surgery, completing that training in 1988. In 1990 he took up the position of lecturer in oral and maxillofacial surgery at the University of Melbourne, became senior lecturer in 1997 and is now a Fellow of the Australasian College of Dental Surgeons.

4.2 Dr Smith’s opinions were:

- The patient had a severe maxillary defect. The jaw had had no teeth in it for some significant time. The jaw had resorbed. Resorbition of the jaw allows the jaw to shrink apparently upwards and posteriorly. This means

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<sup>21</sup> Transcript 133

<sup>22</sup> Transcript 136

<sup>23</sup> Transcript 140

<sup>24</sup> Transcript 146

that the volume of bone that is left makes it very difficult on occasions for adequate replacement with implant.<sup>25</sup>

- The complexity of this case would range in the severe.<sup>26</sup>
- Because there has been an under-assessment of the case from the outset, this has resulted in the likelihood of failure being very high. This is because the under-assessment makes it difficult for successful bone volume to be achieved, for implants to be inserted adequately...<sup>27</sup>
- In terms of training to provide the complexity of surgical treatment that is required here, I do not believe that he (Dr Fibishenko) has shown that he has suitable training to be able to do the sort of treatment that was required for this complexity of case.<sup>28</sup>
- I believe that in this case a referral for a second opinion would have been most appropriate. I think it important to note that even the most experienced specialist surgeons, a case of this complexity might well have then considered to ask for opinion from their peers as to the variety of treatment options that were open to this patient.<sup>29</sup>

4.3 Of course the evidence of both Dr Chen and Dr Smith was far more wide ranging but it would not be of additional value to explore their opinions and evidence further. They gave evidence of esoteric nature not directly addressing the allegations in the Notice.

4.4 The Panel is impressed by the evidence of Drs Chen and Smith. It is obvious that in 2002 each was vastly more experienced than Dr Fibishenko. The Panel has noted that Dr Fibishenko has produced an enormous amount of material by way of affidavits, reports, articles, etc, but the Panel is uneasy about some disingenuous elements of his material and the material that does not address the central issue of his training and experience.

### **Evidence of Dr Anthony Collins**

5.1 Dr Collins is a general dentist who commenced practice in 1974 and therefore has very considerable experience in dentistry.

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<sup>25</sup> Transcript 216

<sup>26</sup> Transcript 217

<sup>27</sup> Transcript 217

<sup>28</sup> Transcript 218

<sup>29</sup> Transcript 229

- 5.2 Dr Collins referred to the “demarcation dispute” by saying there is clearly a legitimate place for appropriately trained and qualified general dentists.
- 5.3 Dr Collins agreed that it was important to stay within the limits of your own capabilities.<sup>30</sup>
- 5.4 Dr Collins was specifically asked whether the treatment provided by Dr Fibishenko to Ms AB was more complex than Dr Fibishenko’s training and experience would properly allow. Dr Collins thought it was a reasonable thing for him to do but he added, “I don’t have details about the patient to know the clinical situation”.<sup>31</sup>
- 5.5 Dr Collins said of the treatment, “It wasn’t one procedure, it was a series of procedures and...in themselves taken step by step were not inherently risky or dangerous”.
- 5.6 Dr Collins summarised his understanding of Dr Fibishenko’s education and training at page 560 of the Book. The Panel is of the opinion that the information provided to Dr Collins was not entirely accurate. For example it seems that Dr Collins believes that Dr Fibishenko had received “training on sinus lifts and grafting techniques by...Dr Robert Marx and Dr Charles Babbush”.  
So far as the Panel is concerned any such training was didactic, not clinical.
- 5.7 Dr Collins also said:  
“In cases that are obviously complex, it seems an ethical though not necessarily a statutory requirement to let the patient know that there may be other practitioners more qualified or capable, and that he or she is entitled to consult them.”<sup>32</sup>
- 5.8 Dr Collins also said:  
“My limited reading of this case does not reveal that any statutory boundaries were crossed or that any substantial harm was occasioned to the patient. Rather, the matter at issue seems to concern precisely the demarcation between who is most qualified to undertake this complex case, with an underlying assumption that a practitioner who is not a specialist in some area should not be considered qualified.”<sup>33</sup>

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<sup>30</sup> Transcript 833

<sup>31</sup> Transcript 856

<sup>32</sup> Book of Evidence p 557

<sup>33</sup> Book of Evidence p 558

5.9 The Panel is aware that that is not the issue, although the Notice does refer to “specialists” in paragraphs (f) and (j)(iii).

### **Evidence of Dr John Giblin**

6.1 Dr Giblin’s evidence was focused on the appropriateness of the treatment provided by Dr Fibishenko, which the Panel notes is not the main issue in the case.

6.2 Dr Giblin expressed no doubt that “Dr Fibishenko is suitably qualified as a general dentist to perform implant treatment that involves bone grafting”.<sup>34</sup> The Panel is unsure whether Dr Giblin is speaking of the present, or 2002.

6.3 Dr Giblin also believed that Ms AB was “a drinker, smoker and had an anxious personality”. The Panel does not accept that Ms AB was a non-compliant patient.

6.4 Dr Giblin considered the treatment plan to be reasonable, and in this he agreed with Dr Chen.

6.5 Dr Giblin would not agree that Ms AB’s was a complex case. He said, “No, it’s a lot of procedures to be done in one go.”<sup>35</sup> “There are more variables – variables complications. More complications could arise.”

6.6 Dr Giblin was challenged in cross examination to state the basis for his assertion that he had no doubt Dr Fibishenko was suitably qualified. The transcript reveals that Dr Giblin had made some assumptions about Dr Fibishenko’s clinical training that could not be substantiated. Further, he knew nothing of the screw in denture fixed to the palate.

6.7 Dr Giblin said he kept a log of every procedure he performed – “sinus lifts – everything. I have one girl dedicated to it.”<sup>36</sup>

### **Law as to Determinations**

7.1 The function of a determination under the Act is protective, not punitive.<sup>37</sup>

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<sup>34</sup> Book of Evidence p 567

<sup>35</sup> Transcript 786

<sup>36</sup> Transcript 819

<sup>37</sup> Morris v Psychologists Registration Board

- 7.2 “The power of the Court to discipline a barrister is...entirely protective and notwithstanding that its exercise may involve a great deprivation to the person disciplined, there is no element of punishment involved.”<sup>38</sup>
- 7.3 Justice Kellam in *Parr v Nurses Board of Victoria*<sup>39</sup> commented that whether a person is found to have engaged in unprofessional conduct of a serious nature must depend on the facts of the case:
- “Clearly such conduct would not be serious if it was trivial, or of momentary effect only at the time of commission or omission. It must be a departure, in a substantial manner, from the standards which might reasonably be expected of a registered nurse. The departure from such standards must be blameworthy and deserving of more than passing censure”.
- 7.4 In reaching its decision the Panel has been guided by the law stated in *Briginshaw v Briginshaw*<sup>40</sup>, and in particular by the well known remarks of Dixon J.
- 7.5 The Panel considers that there is a degree of overlapping in the allegations B(g) and (h).
- 7.6 The Panel emphasise that these allegations relate to events in 2002. The decision is not intended to reflect adversely on Dr Fibishenko’s practice of dentistry since that time. The Panel acknowledges that Dr Fibishenko has since gained more education and experience and the Panel has no reason to believe that the public has need of protection from Dr Fibishenko in any sense.

Mr Michael Gorton  
Chair  
11 February 2008

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<sup>38</sup> New South Wales Bar Association v Evett (1968) 117 CLR @ 183

<sup>39</sup> Unreported VCAT 2/12/98

<sup>40</sup> (1938) 60CLR 336