

# THE DENTAL PRACTICE BOARD OF VICTORIA

## Dr Jonathon Hartley [2008] DPBV 4

<b>Panel:</b>	<b>Ms Deborah Foy (Chair)</b> <b>Dr Gerard Condon</b> <b>Dr Pamela Dalglish</b>
<b>Counsel Assisting the Panel:</b>	Mr P Monahan of Monahan + Rowell, Lawyers
<b>Counsel for the Practitioner:</b>	Mr I Freckelton SC instructed by DLA Phillips Fox
<b>Dates of Hearing:</b>	26 March, 30 April, 7 May 2007 and 16 January 2008
<b>Date of Decision:</b>	20 May 2008

### **FINDINGS**

Pursuant to section 47(1)(a) of the *Dental Practice Act 1999* (“the Act”), the Panel having considered the evidence and submissions placed before it, and taking into account the admissions made by Dr Hartley to allegations contained in paragraphs (a) to (qq) of the Notice of Formal Hearing, finds Dr Hartley has engaged in unprofessional conduct as defined in paragraphs (a) and (b) of the definition of “unprofessional conduct” in section 3 of the Act and that conduct is of a serious nature.

### **DETERMINATIONS**

Having given due weight to the submissions placed before the Panel, and in acknowledging the admissions made by Dr Hartley, the Panel considers it appropriate under section 47(2) of the Act to:

- Reprimand Dr Hartley for his conduct in relation to Ms AA;

- Caution Dr Hartley about his conduct with respect to female patients in particular and that in the event of a further complaint which relates to similar conduct in the future caution him that the Board will consider suspending his right to practice;
- Require Dr Hartley to undertake additional training in endodontic treatment of at least one full day with a person authorised by the Board at his expense. Such training to be completed by 31 July 2008.
- Impose a Fine of \$6,000. This fine is to be paid within 30 days of the receipt of the Reasons document.
- Place a condition on Dr Hartley's registration that at his expense, he submit to regular audits of his compliance with the Code of Records Management on a three monthly basis for 12 months followed by a further six monthly audit for the following 12 months by a person authorised by the Board.
- Require Dr Hartley to continue his counselling sessions with Dr Michelle Pathé (or a person approved by the Board), and to provide six monthly reports from Dr Pathé to the Board. This counselling is to continue until Dr Pathé determines no further counselling is required.

## Reasons for Decision

1. The allegations heard by the Panel are contained in a Notice of Formal Hearing which described the allegations against Dr Hartley below:

“(a) At all material times, you have been registered as a dental care provider in Victoria under the Act, having been registered as a dentist in Victoria since 10 December 1969.

### Introduction –The Patient

- (b) You provided dental treatment to a patient named Ms AA at your surgery at 227 Commercial Road, South Yarra on Friday 29 October 2004.
- (c) A copy of your patient card dated 29 of October 2004 containing your record of the treatment provided to Ms AA is **attached**.

### Inappropriate Language and Conduct

- (d) In the course of providing dental treatment to Ms AA, she felt anxious and uncomfortable. She had also explained to you that, as a child, she had fallen and broken many of her teeth.
- (e) In those circumstances, you told Ms AA (in words roughly to the following effect) that the reason she felt emotional in the dentist’s environment was because her experience as a child was like “*being orally raped with parental consent*”.
- (f) You further expressed the view to Ms AA that her problems in relationships were due to that experience and her power issues were also related. You continued to say (in words roughly to the following effect) that you were the one with the power now and that you were going to do your job and there was nothing (Ms AA) could do about it.
- (g) This conduct was unacceptable and inappropriate, and constitutes unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.
- (h) That unprofessional conduct constitutes unprofessional conduct of a serious nature.
- (i) In particular in that regard:-
  - (i) In May 2004, you were subject to a Formal Hearing by this Board under the Act concerning your treatment of another female patient, Ms K;

- (ii) The allegations against you in that Formal Hearing bore a similarity to the allegations in this matter;
- (iii) On 17 August 2004, the Panel of the Board conducting that Hearing found that you had engaged in unprofessional conduct, not of a serious nature, after finding that you had behaved inappropriately in dealing with your patient in the respects set out in paragraphs 3.1 to 3.6 of the Panel's Findings (copy **attached**);
- (iv) As a result of that Finding, the Panel reprimanded you and cautioned you in respect of your unprofessional conduct. Further, the Panel ordered that you undergo counselling with a Board-appointed counsellor for a twelve month period, with the counselling to address at least the following issues:-

*“Appropriate behaviour by a dentist with his patients in a current practice in Victoria, addressing issues such as appropriate professional boundaries, use of appropriate language in the doctor/patient context, doctor/patient communications generally and the avoidance of inappropriate physical contact with patients”.*

- (v) A copy of the Determination is **attached**, and you are referred to the full terms of the Determination;
- (vi) In particular, the last sentence of paragraph 57 and the whole of paragraph 59 of the Determinations stipulated as follows:-

*“It is for this reason also that the Panel has made the determinations which it has in an endeavour to protect the public by giving Dr Hartley the opportunity to be counselled about what is appropriate behaviour in the professional setting...*

*Dr Hartley should however take no comfort from the fact that this Panel did not make a finding of unprofessional conduct of a serious nature. The matters complained of by the complainant in this instance were of a more serious nature than that made against Dr Hartley in the Notice of Formal Hearing dated 16 May 2002. It is concerning that the*

*escalation in the inappropriate conduct took place so soon after the counselling session on 26 August 2002. If Dr Hartley does not change his conduct and adopt a more professional relationship with his patients in line with current community attitudes then he may well find himself again the subject of a complaint”.*

- (vii) You thereafter commenced counselling with Dr Michelle Pathé, and first saw Dr Pathé on 8 October 2004, three weeks before you treated Ms AA;
- (viii) You accordingly had the benefit of counselling from Dr Pathé at the relevant time;
- (ix) At your counselling session with Dr Pathé on 8 October, she encouraged you to carry on seeing your own psychotherapist, and you accordingly also had the benefit of such psychotherapy at the relevant time.
- (j) Notwithstanding all of the matters set out in paragraphs (i) and (j) above, you engaged in unacceptable inappropriate and unprofessional behaviour in your treatment of Ms AA on 29 October 2004, in the respects set out in paragraphs (d) – (f) above.
- (k) Accordingly, your conduct constitutes unprofessional conduct of a serious nature.

#### **Dental Work Done Without Consent**

- (l) During the course of the treatment which you provided to Ms AA on 29 October 2004, you performed root canal therapy on her tooth 37.
- (m) You did not obtain Ms AA’s consent to that treatment.
- (n) At the conclusion of the treatment, you informed her what you had done and that the cost would be of the order of \$1,500.
- (o) That work was performed without the patient’s prior consent and, in addition, she was not provided with any information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed, or the cost of that treatment, before the treatment was commenced.

- (p) You accordingly failed to ensure that your patient had all the necessary information and details available to her at an appropriate time concerning such treatment, before you commenced that treatment.
- (q) You have accordingly engaged in unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.
- (r) That unprofessional conduct constitutes unprofessional conduct of a serious nature.

### **Misleading Behaviour**

- (s) Prior to commencing dental treatment with you, Ms AA was informed by your staff (acting in the course of their employment and on your instructions and authority) that “*she would be quoted prior to any treatment*”.
- (t) You knew, or ought to have known, that your staff member had made this statement to Ms AA before she commenced her treatment with you.
- (u) Ms AA was not given any quote for the proposed root canal therapy prior to that treatment being undertaken by you.
- (v) Accordingly, Ms AA was misled in this regard by you and/or by your staff, acting under your instruction and authority and in the course of their employment.
- (w) You have accordingly engaged in unprofessional conduct, as defined in Section 3 of the *Dental Practice Act 1999*.
- (x) That unprofessional conduct constitutes unprofessional conduct of a serious nature.

### **Treatment Provided – Item 222**

- (y) Your patient records and your accounts to Ms AA record that you performed the dental treatment described in the Australian Schedule of Dental Services and Glossary (8<sup>th</sup> edition) (“*the Glossary*”) as item number 222 (“*root planing and subgingival curettage – per eight teeth or less*”) in four quadrants.
- (z) Your account records that Ms AA was charged four separate fees for item number 222, initially \$50 each and thereafter reduced to \$25 each.
- (aa) In truth and in fact, you did not perform the dental treatment described in the Glossary under item 222 at all, and have

incorrectly charged Ms AA for work which you did not perform.

- (bb) Alternatively, if you did provide that dental treatment, it was unnecessary and not indicated, given your own observation that Ms AA had no periodontal disease and no pockets over one millimetre.
- (cc) Rather, the dental work which you did perform, and which you were requested by your patient to perform, was a Scale and Clean (item number 114 in the Glossary), and the patient should have been charged for that procedure.
- (dd) Your conduct in this regard constitutes unprofessional conduct, as defined in Section 3 of the *Dental Practice Act 1999*.
- (ee) That unprofessional conduct constitutes unprofessional conduct of a serious nature.

**Treatment Provided – Items 415 and 416**

- (ff) Your patient records and your account numbered to Ms AA record that you performed the dental treatment described as items numbered 415 and 416 in the Glossary as follows –
  - 415 – *“Complete chemo-mechanical preparation of root canal – one canal”*; and
  - 416 – *“Complete chemo-mechanical preparation of root canal – each additional canal”*.
- (gg) Your account records that Ms AA was charged two fees, one for item number 415 and another the item number 416, initially \$375 each and thereafter reduced to \$250 and \$125 respectively.
- (hh) In truth and in fact, you did not perform the dental treatment described in either item 415 or item 416 of the Glossary, but rather performed the work described in item 419 of the Glossary (*“extirpation of pulp or debridement of root canal(s) – emergency or palliative”*).
- (ii) Accordingly, you have incorrectly recorded the work which you performed, and incorrectly charged Ms AA for work which you did not perform.
- (jj) Alternatively, if you did in fact attempt to provide the dental treatment described in items 415 and 416 of the Glossary in

treating tooth 37 of you patient Ms AA, then the dental work which you provided in regard to such services 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 or her peers.

(kk) In particular in this regard:-

- (i) The canals of tooth 37 were only partially instrumented, and only a small amount of instrumentation had been performed on those canals;
- (ii) Not all of the pulp or necrotic debris had been removed from those canals;
- (iii) Accordingly, there had not been complete chemo-mechanical preparation of any of the root canals of tooth 37.

(ll) Your conduct in these respects constituted unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.

(mm) That unprofessional conduct constitutes unprofessional conduct of a serious nature.

### **Record Keeping (General)**

(nn) The Dental Records which you maintained of your treatment of Ms AA in October 2004 were inadequate and inappropriate in the following respects:-

- (i) They failed to comply with Code of Practice No. C003 (Dental Records) promulgated by the Board in August 2003 under Section 69(1)(e) of the Act;
- (ii) A list of the respects in which your dental records failed to comply with the Code, and were deficient, is **attached**.

(oo) Your failure to maintain appropriate dental records of your treatment of Ms AA constituted unprofessional conduct as defined in Section 3 of the Act.

(pp) Such unprofessional conduct was of a serious nature.

(qq) In particular in that regard, you had received earlier counselling from two officers of the Board on 26 August 2002 concerning record keeping and, notwithstanding such counselling, have again maintained inadequate and inappropriate dental records.”

2. The hearing was concerned with allegations concerning remarks made by Dr Hartley to Ms AA the complainant concerning the causes of her anxiety with respect to dental treatment, his failure to obtain consent from Ms AA before commencing root canal treatment, the match between his use of various item numbers in the invoice given to her and his treatment and his record keeping. A further allegation concerned his failure to respond to previous findings made against him in informal and formal hearings before the Board.
3. Ms AA was a very anxious patient, a fact acknowledged by her in her evidence and by other dental care providers. She had had an accident in childhood, which lead, in her childhood, to a series of painful sessions of dental work. At the time of making her appointment, she was not a resident of Melbourne but was working in Melbourne in a position with very tight deadlines and sought treatment from Dr Hartley to deal with a tooth which was giving her trouble, anticipating a relatively short attendance with Dr Hartley. At the time of making the appointment, she requested treatment with nitrous oxide as she knew that this would assist in managing her anxiety. She also suffered from Graves disease which she stated on the medical history chart which she completed prior to the appointment.
4. Dr Hartley also commenced root canal therapy without consent from Ms AA and initially charged her \$1500 for the services provided on that day. This fee was subsequently waived.
5. Dr Hartley made significant admissions with respect to a number of the allegations related to his treatment of Ms AA. The Panel acknowledges those admissions.
6. Some of the allegations refer to matters of fact which were not disputed by Dr Hartley. Specifically, the allegations contained in paragraphs (i) and (qq) referred to previous hearings and the determination of the Panel and subsequent implementation of those determinations.
7. However, Dr Hartley disputed a number of matters in relation to a number of the allegations and the Panel’s reasons with respect to those areas are outlined below in reference to each of those disputes as follows:

## **Allegations in paragraph (f)**

### **Inappropriate language**

8. The allegation in paragraph (f) concerned the language used by Dr Hartley in his conversation with Ms AA concerning her childhood dental history.
9. Ms TT, Dr Hartley's receptionist told the Panel that Ms AA was a very anxious patient. Dr Hartley was in the reception area when Ms AA arrived. He would have observed her agitation and at the appointed time he approached her and took her into either the reception into the surgery or to have an X-ray. He treated and approached her in his usual sympathetic sort of manner.
10. Ms TT also told the Panel that as Ms AA left the surgery she was very upset, she was crying. In light of her agitation Ms TT told the Panel that although another appointment was indicated she told Ms AA that she would call her. She said she had made out the account to give her and handed it to her, saying "look, we will handle this at a later stage."
11. She told the Panel that she was very concerned about a patient leaving the practice in such a distressed state it and had relayed this to Dr Hartley at the time.
12. Dr Hartley told the Panel that at the beginning of her attendance, Ms AA had informed him that when she was a little girl she had fallen off a tricycle and smashed her front teeth. She was rushed to the dentist by her parents in a painful state and she was held down while the dentist did what he had to do to relieve her pain. She told Dr Hartley that she hadn't been to a dentist for many years to get her teeth cleaned and she also had a painful tooth.
13. In response, Dr Hartley had said, "well, it seems to me that how it looks to me is that you were orally raped with parental consent". He explained to the Panel that he was endeavouring to take a very sympathetic manner with Ms AA. He now agreed that it was insensitive.
14. However, he denied that he had expressed a view "that he was the one with power now and that he was going to do his job and that there was nothing Ms AA could do about it' ("the power statement").
15. The Panel accepts that it is unlikely that he made the power statement. While the Panel accepted that Ms AA honestly believed that he had made such a statement, as she was a credible and consistent witness, the Panel accepted Dr Hartley's evidence on this issue. When he was asked about whether or not he had made the power statement, he denied that he could possibly have used such words.

16. He told the Panel that such a statement would be absolutely the worst thing to do as his objective was to get her to relax and comfortable and give her power. He suggested that Ms AA had in some way distorted what he said. He had never said anything similar to a patient in all his practising life.
17. The Panel accepts that Dr Hartley made all his remarks to Ms AA with an intention of expressing empathy to her and not an intention to make her uncomfortable and disempowered. While it is certainly correct that his remarks had that effect, the Panel doubts that Dr Hartley would have made such a remark with the deliberate intention of increasing Ms AA's sense of vulnerability.
18. Nonetheless, it is likely that a conversation did take place about power relationships between dentist and patient and may have given rise to a misunderstanding on Ms AA's part.
19. There was some suggestion that the effect of nitrous oxide may have played a part of Ms AA's recollections of that day but the Panel gave little consideration to that issue.
20. Consequently, the Panel did not find the allegations in paragraph (f) made out.
21. Further, the Panel finds that the allegations concerning previous hearings and the counselling required to be undertaken by Dr Hartley concern statements of fact and therefore cannot constitute matters of conduct. However, the information concerning those hearings and the requirements placed on Dr Hartley by the determinations made at those hearings can and did influence the Panel's determinations.

### **Allegations in paragraph (l)-(r)**

#### **Dental work done without consent**

22. These allegations concern whether or not Dr Hartley obtained Ms AA's consent for commencing root canal work without discussing either the treatment itself, the advantages, disadvantages, risks or benefits or cost of the treatment with her.
23. Dr Hartley admitted these allegations. Ms AA gave evidence that there had been no suggestion to her that she might need to have root canal treatment.
24. Dr Hartley described his examination of Ms AA's dentition and told the Panel that "Her oral hygiene was exceptionally good and so a lot of her calculus was supra gingival."<sup>1</sup>

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<sup>1</sup> Transcript p.194

25. She had very deep deposits of heavy calculus around most of her teeth and a little bit of bleeding around some of the six year old molars but not much.” He also outlined the progress of his treatment of Ms AA. He told the Panel that when she initially described her symptoms, as “just a mild ache on chilling”, all he believed was required was “a very, very heavy clean and quick filling”. He was aware of her anxiety and told the Panel that from time to time during his treatment, Ms AA became distressed. Both her anxiety and the need to monitor the nitrous oxide meant that there were breaks in her treatment.
26. An hour had been set aside for her appointment as Ms AA requested nitrous oxide at the time of making her appointment and she had needed a lot of work done. He commenced to work on tooth 37 then after a conversation with Ms AA. He had managed to undertake treatment with the assistance of nitrous oxide. He continued treatment and at the conclusion of cleaning and root planning and subgingival curettage, he thought that he would be able to place a temporary filling in the tooth, which was troubling her.
27. He told the Panel that he found a big cavity in the tooth and he put in a sedative dressing, as her symptoms at the time were mild. He noticed some bruxing and did a minor occlusal equilibration at the time. He told the Panel that she said that was an improvement but she could still feel it when she bit hard. The tooth was vital with only signs of infection in the dentine. He told the Panel that when he told her that she had a big cavity she started to cry more. He told the Panel that his failure to tell her was his error as she was still receiving nitrous oxide and he should have taken her off the nitrous oxide and made sure she understood. He told the Panel “I didn’t think of it at the time”.
28. He did not discuss the cost of nitrous oxide or any other procedure with her. His explanation for not doing so was her anxiety. He also said that he was aware that she had taken this time off and specifically made this appointment and that she had “wanted me to do everything I could”.
29. Dr Hartley told the Panel that he did not observe any infection contrary to Dr Lew’s evidence that he saw the patient shortly afterwards and described her on a number of occasions as having an infection.
30. During his work on the tooth, Ms AA’s boyfriend attended in the clinic as he had come to collect Ms AA. Dr Hartley told the Panel that he had thanked him for coming and then explained, “we’ve had a bit of a problem here, I’ve had to start a root canal treatment”. He gave evidence that Mr DD said “we’ll deal with that later, let’s just look after Ms AA now”.

31. Dr Hartley agreed that he had taken Mr DD's comment as an authorisation for him (Dr Hartley) to proceed with the root canal treatment without her having given clear consent. Dr Hartley agreed that such an authorisation was insufficient.
32. Dr Hartley told the Panel that at the end of the session, after completing the debridement of the two canals, I put the cavit in, took the rubber dam off and put the chair up for her to have a rinse, at which time I informed her that I had started the root canal treatment. Ms AA became very distressed again and he realised that he couldn't have a conversation with her, I couldn't even put her back to remove the cavit that was probably high. I was assuming to see Ms AA again after she'd calmed down to remove the cavit and to reassess the whole procedure.
33. Given his admission, when asked about the legitimacy of not having a full and clear discussion with her about her options and the potential side effects and the advantages and disadvantages of one form of treatment as against another, he told the Panel that he was not expecting to perform root canal therapy when he first examined her teeth.
34. He told the Panel that he had changed his practice and "when he'd reached the point of recognising that root canal work was necessary the procedure in the office now is to stop everything and usually make another appointment".<sup>2</sup>
35. There was some inconsistency in Dr Hartley's evidence as to whether or not he mentioned the possibility of root canal therapy to Ms AA. He told the Panel that he raised the possibility of a root canal treatment and his notes suggest that he did. In evidence, he told the Panel that he should have discussed it with Ms AA before starting the procedure but he also told the Panel that he did not want to wake her up to ask her consent and that therefore he proceeded without consent.
36. At one point he also told the Panel that "(he)" thought that she'd wake up from the anaesthetic in intense pain and I made a clinical judgment without consent and I did it and that's that.<sup>3</sup>
37. The Panel preferred Ms AA's evidence on this issue and consequently does not accept that Dr Hartley mentioned or raised the possibility of a root canal treatment prior to his decision to go ahead with the treatment.

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<sup>2</sup> Transcript p.199

<sup>3</sup> Transcript p.266

38. He acknowledged that he had made the wrong clinical judgment in proceeding. He added that he could remember thinking at the time, "this girl's come in just complaining of a mild toothache, she must have been suppressing it pretty well."<sup>4</sup>
39. He told the Panel that he decided to go ahead with the root canal treatment without consent because he thought it was in her best interests at the time.
40. He also accepted wholeheartedly that his conduct in doing so was paternalistic and did not accord with the principles of patient autonomy.

#### **Treatment provided Item 222**

41. It was alleged against Dr Hartley that during the course of treatment for Ms AA, he purported to have undertaken root planning and subgingival curettage when it was not required and that in fact was not the treatment given. It was suggested that Dr Hartley used this item number incorrectly to enable him to charge Ms AA a higher fee than was warranted.
42. In support of this allegation, Counsel Assisting the Panel called Dr Werner Bischof who gave evidence and provided a report to the Panel in which he stated "In the absence of gingival and/or periodontal pathology (he) would not expect the requirement for any treatment particularly the procedure of root planning and gingival curettage."<sup>5</sup> At the time of writing, he was aware of Dr Hartley's note to the effect that Ms AA had no periodontal disease and no pockets over 1mm.
43. Dr Bischof subsequently gave oral evidence to that effect and told the Panel that further he could not contemplate undertaking such treatment for all four quadrants in under two hours and without local anaesthetic, even with the use of nitrous oxide.
44. Dr Roseman, the Board's Investigating Officer gave evidence on this issue and told the Panel of the significance of an ADA number. The ADA schedule is a series of numbers and identifying particular procedures for all aspects of dentistry that is used as a shorthand way of describing procedures by the dental profession and it's also used by the health funds for identifying rebates for clients of the health funds. He also explained the significant difference between the rebate that a patient would obtain from a health insurance fund under Item 222, particularly for four quadrants of work done in one session and Item 114. The rebate for 114 is \$33 and the rebate for 222 is \$40, but if you did four items of 222, the rebate is \$160.

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<sup>4</sup>Transcript p. 200

<sup>5</sup> Letter from Dr Bischof to Dr Anthony Roseman 21 March 2005.

45. Dr Hartley, in his evidence, told the Panel that he did not agree that local anaesthesia needed to be used in every 222 procedure. Further, he said it would not have been painful for Ms AA, as she had had the effect of the nitrous oxide and his monotonous voice.
46. Dr Hartley initially gave evidence about his experience in the use of nitrous oxide as he now used it three or four times a year.
47. He gave evidence about the techniques that he used to deal with people who are particularly apprehensive or fearful of dentists and described his experience in the 1970s with intellectually disabled children and the use of general anaesthetic. This had led him to an interest in developing hypnotic techniques to address anxieties both amongst intellectually disabled patients and others.
48. He explained that nitrous oxide is an aid to hypnosis and relaxing techniques. He noted that in his experience time distortion and forgetfulness were the most significant side effect of the use of nitrous oxide.
49. More recently he had done some research about the consequences of the usage of nitrous oxide that suggested that nitrous oxide affected short-term recall.
50. Dr Hartley subsequently agreed with Dr Bischof's evidence that it is a matter of clinical judgment as to whether a procedure crosses the line into properly being classified as item 222 or against an item 114 procedure and suggested that if Dr Bischof treated the patient he probably would have done exactly as Dr Hartley did.
51. Dr Hartley also agreed that it would be uncomfortable if the patient were very awake and aware.
52. He said that Ms AA coped "quite well" with the procedure in these four quadrants and did not indicate that she was in pain.
53. Again, there were inconsistencies in Dr Hartley's evidence with respect to this issue. At one point, some four weeks after his appointment with Ms AA, he told the Panel in writing to the Board on 26 November 2004, p.94 that there were no pockets over 1mm but during the hearing, he gave evidence that he had needed to remove granulated tissue to a level of 2mm. He then told the Panel that he had not actually measured the depth of pockets, which meant that he had no means of measuring any progress subsequently. Dr Hartley told the Panel that despite Ms AA's good oral hygiene, her teeth had required removal of cementum and a heavy clean
54. He also told the Panel that in the hour that he had spent in undertaking this treatment there had been several interruptions due to Ms AA's anxiety.

55. Further, he told the Panel that Ms AA had not complained of pain during the procedure.
56. In his letter of 8 November 2004 to the Board written in response to Ms AA's complaint, Dr Hartley had described Ms AA as having no periodontal disease and no pockets over one millimetre.
57. When asked how that could be reconciled with the description he had given of very deep deposits of heavy calculus around most of her teeth and a little bit of bleeding around some of the six year old molars, he told the Panel that the fact that she had no active disease did not mean that she had no periodontal disease.
58. Given Dr Bischof's evidence with respect to the pain usually experienced by patients, the evidence given by Dr Hartley in his letter as to the absence of pockets greater than 1 mm and the time normally taken to plane and curette in all four quadrants, the Panel was not satisfied that the use of item 222 was warranted in the circumstances and did not accept Dr Hartley's evidence on this matter.

#### **Allegations regarding the use of item numbers 415 and 416**

59. It was alleged against Dr Hartley that he had charged Ms AA for complete chemo-mechanical preparation of three root canals when he had not completed the preparation and further, that the treatment he had performed was of a poor standard.
60. Dr Hartley admitted the allegation insofar as he agreed that the work that he had undertaken could better be described as emergency or palliative removal of pulp rather than complete chemo-mechanical preparation. He denied, however, that his work had been of a lesser standard than would have been expected by the public or his peers.
61. Counsel Assisting the Panel called evidence from Dr CC who had treated Ms AA on 1 November 2005, 11 days after her attendance at Dr Hartley's rooms. She was complaining of pain in tooth 37. He subsequently treated her again on 5 November 2005.
62. Dr CC told the Panel that he had debrided and cleaned each of the three canals and placed Ledermix cement and sealed the tooth with cavit.
63. He observed that, in his opinion, none of the three canals were debrided very well. He told the Panel "I can't remember if one was more debrided than another one but all three seemed to be fairly undebrided."<sup>6</sup>

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<sup>6</sup> Transcript p.96

64. He believed that the level of instrumentation that had been done on those canals constituted approximately 10 to 15 per cent of a complete chemo-mechanical preparation.
65. In cross-examination, he acknowledged that Ms AA had been a very nervous, anxious patient and that it had been difficult to adequately examine her teeth. He also agreed that he could not recall any distinctions between the canals and that if one was in worse condition than the other two, he would not have paid particular attention to it as his intention was to remove necrotic material from all three.
66. Dr Hartley explained to the Panel that his criteria is “to get three rounds of white dentine at the apex seat.” He also explained that when he realised that Ms AA would not be returning to him, he thought, “Whoever is following on from me won't have much of a job ahead of them. They had one canal to finish out and then the job will be over.”<sup>7</sup> He did not think there would be infected tissue in the tooth only a week later.
67. He did not recall there being any debris left in those canals when he completed his work.
68. He explained that he did not continue to finish off the third of the three canals because he thought “enough was enough” at the time of her appointment and that he would have a further opportunity to finish the root canal treatment. He explained that had Ms AA returned, “I would have checked that, I would have done any minor shaping if I wasn't happy with any of it, but I doubt it, and would have washed them again with Miltons and proceed to dry them and fill them.”<sup>8</sup> He did not fill them with Ledermix as in his view this was not appropriate, as they were not infected.
69. He also commented that Dr DD's finding of infected and necrotic material in all three canals would be very unlikely unless the seal was broken.
70. In his submissions, Counsel for Dr Hartley suggested that there was sufficient evidence to conclude that Dr Hartley took appropriate lengths that his drilling of the two canals, which he did, was appropriate and broadly comparable to the treatment undertaken by Dr DD. Counsel for Dr Hartley suggested that the tooth had deteriorated by the time of his treatment of Ms AA requiring the further work done ultimately by Dr DD.
71. Dr Roseman also gave evidence that if two out of three canals are cleaned without a seal, the canals are likely to become infected if one is an infected canal, into another canal.

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<sup>7</sup> Transcript p.203

<sup>8</sup> Transcript p.205

72. The Panel accepted the evidence of Dr Hartley on this issue and accordingly, while the Panel found that the canals in tooth 37 were adequately instrumented in the circumstances facing Dr Hartley at the time of his treatment, it was likely that not all debris had been removed, given Dr Hartley's intention to undertake further work.
73. Consequently in light of Dr Hartley's admission with respect of the use of item numbers 415 and 416, the Panel determined that Dr Hartley's conduct was in this respect unprofessional, but not of a serious nature.
74. However, the Panel was concerned at Dr Hartley's description of his management of the canals after he had concluded the instrumentation because of his failure to use appropriate medicaments to reduce the possibility of further contamination. The Panel asked Dr Hartley questions concerning his observations of the periapical X-rays taken for Ms AA which raised a concern regarding his diagnostic skills.

#### **Allegations regarding record keeping**

75. Counsel Assisting called Dr Roseman, the Board's Investigating Officer who gave evidence regarding the Dental Board's Code of Practice issued by the Board in August 2003 and on the Board's requirements for keeping of dental records and its promulgation. He also told the Panel of his assessment of the dental records maintained by Dr Hartley concerning his treatment of the patient in this case.
76. Dr Roseman listed a number of criticisms of Dr Hartley's dental records that were accepted by Dr Hartley with three exceptions.
77. First, Dr Hartley disagreed that he had failed to maintain a record of the presenting complaint as Dr Hartley did note that his record stated, "Chewing on left side is a problem" and "Do you have headaches or neck aches", "Sometimes". In Dr Roseman's view, such a notation would require more follow up to be an accurate comment on a presenting complaint.
78. Second, he contested Dr Roseman's criticism regarding the absence of a record of relevant history of Ms AA. Dr Hartley provided the Panel with a document indicating that there was some medical history taken of Ms AA but no dental history. This had been provided after Dr Roseman had examined the records. Dr Roseman had been critical of the fact that there was no mention of Ms AA suffering from Graves disease in Dr Hartley's notes. One of the symptoms of Graves disease is anxiety. He told the Panel that if Dr Hartley had adequately identified and recorded that she had suffered from Graves disease, this may have alerted him to one of the possibilities of her being anxious and nervous.

79. Dr Hartley acknowledged he had been very dismissive about the information that Ms AA suffered from Graves disease that he did not think it was relevant.
80. Further, Dr Roseman was critical of the absence of notes about her periodontal condition or periodontal examination. In relation to endodontic issues, Dr Roseman told the Panel that the notes only indicated "open and drain" and history of chewing on the left side but nothing with respect to identification of the tooth and indication of any examination to identify which tooth it was, whether it was tentative percussion or not, whether it may have had a fractured cut and whether it was vital or non vital and carbon dioxide tests.
81. Further, Dr Roseman stated that there was nothing in the notes which indicate the level of instrumentation of the canals which he believed constituted poor record keeping as it provided no mechanism to measure the progress of endodontic treatment.

#### **Allegations with respect to previous hearings**

82. The determinations with respect to previous hearings constitute matters of fact and can, in the Panel's view, only be considered with respect to its final consideration of its determinations in this hearing.
83. These previous findings indicate that Dr Hartley has been a "repeat offender" with respect to three of the matters considered by this Panel; namely obtaining of consent, his client/patient relationships and recordkeeping.
84. Dr Roseman gave evidence regarding counselling that Dr Hartley undertook with Board officers subsequent to an Informal Hearing in June 2002. The three issues that were the subject of that counselling session were informed consent, client/patient relationships and recordkeeping.
85. Evidence was given to the Panel that Dr Hartley had responded to counselling on these matters by way of a letter in which he stated, "As requested, I'm writing to advise the result of our discussion. I'm now giving more time and attention to the areas which were identified as being immediate improvement".
86. As part of that process, he also undertook to improve his periodontal charting. However, in his records of his treatment of Ms AA, there was no record of periodontal charting.
87. In addition, an issue arose in August 2002 about the sufficiency of his records of informed consent. In August 2002, there was a finding of unprofessional conduct not of a serious nature and Dr Hartley received a reprimand and a caution and a requirement to undergo further counselling.

88. He duly commenced the process of further counselling with Dr Michelle Pathé who provided three reports for this hearing. Dr Pathé provided her first report on 8 October 2004. Her first report was written on the day that she saw Dr Hartley for a one and a half hour session of treatment. Some three weeks later, Dr Hartley treated Ms AA on Friday, 29 October 2004.
89. A further report was provided to the Board in January 2005. In the introduction to her report, Dr Pathé stated, "I'm informed that there's been a further complaint against Dr Hartley and (that I have been) asked that my report specifically address the complainant's concerns and my counselling in relation to these matters".
90. By that time Dr Pathé had seen Dr Hartley for four one-hour counselling sessions in November, December and January 2005
91. In December 2005, Dr Pathé provided a third report. By that time, Dr Pathé had seen Dr Hartley at her rooms on 12 occasions between 8 October 2004 and 21 October 2005.
92. In her letter of 8 October 2004, Dr Pathé said that Dr Hartley required further education in relation to boundaries and the impact of boundary crossings and that she proposed to make efforts to enhance his empathy with complainants. She described Dr Hartley as not empathetic with complainants and saw himself as the victim of complainants.
93. In her second report, she described Dr Hartley as seeming more aware of the personal impact of his patients' anxiety and his responses. Dr Hartley agreed in evidence that "I think I just had my head in the sand early on and I was blaming others. I wasn't - I didn't take on the changes that have happened until probably the second or the third appointment. She also wrote "he had been slow to grasp the problematic nature of his conduct but since receiving the (current) complaint he had been more accepting of need for change."
94. Two witnesses, in addition to Dr Hartley, gave evidence as to the changes that had occurred in the practice, Ms TT, Dental Receptionist and Ms SS the Director of Momentum Management.
95. Ms TT told the Panel of changes that had occurred in the practice and said that she thought that Dr Hartley was more aware of patients' needs and that he listened to information from front desk as to what patients requirements are and what their initial consultation is going to be. She commented, "There seems to be more of a routine being set up in the last period since this episode. It seems to run far more smoothly and patients appear to be a lot happier."<sup>9</sup>

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<sup>9</sup> Transcript p.155

96. Evidence was given by Ms SS. She told the Panel that she believed that Dr Hartley's commitment to the implementation of significant changes in his practice and his willingness to change was evident in the way in which he now undertook practice.
97. In responding to a question about previous complaints about using sexually inappropriate language to patients, he acknowledged that he was a flamboyant individual and that he had had a habit of doing that. He explained to the Panel that he had had considerable help in the last three years and now there were very strict guidelines in the practice now of how first patient meetings are conducted. He explained that he had learnt since that it was totally inappropriate to use that language from Dr Pathé
98. In cross-examination, Dr Hartley acknowledged that it was the third time that he had been subject to a Formal Hearing. He told the Panel that he had not realised that his practices were out of touch with current expectations as to the behaviour of a health care practitioner. He told the Panel that he took pride in his work and that he was very distressed by the complaints and the hearings.

### **Determinations**

99. The role of the Panel is to protect the public and to maintain the integrity of the profession. A Code of Conduct established by the Dental Practice Board of Victoria refers to the importance that the Board places on "ensure(ing) that dental care providers maintain professional relationships and standards of interpersonal conduct that serve the best interests of their patients."
100. The Board requires dental care providers to exercise their professional responsibilities by, amongst other things, discussing issues raised by patients in a manner that does not offend them or increase their sense of vulnerability.
101. Further, the Board has published guidelines for dental care providers on assisting patients to make well-informed decisions. The advice provides that doing so is "part of the practitioners overall duty to take reasonable care in looking after a patient."
102. In his treatment of Ms AA, Dr Hartley failed to comply with this obligation and in doing so fell below the standard of conduct expected by the community and from his peers and in doing so, his conduct falls within the category of unprofessional conduct of a serious nature.
103. The *Dental Practice Act* 1999 does not go beyond the definition of unprofessional conduct and define what is not of a serious nature and what is of a serious nature. The meaning of unprofessional conduct "of a serious nature" has been considered in a number of cases. These

include *Parr v Nurses Board of Victoria* (1998) 16 VAR 118 where Kellam J stated that the consideration of the nature of the unprofessional conduct must depend on the facts of the case and further said:

“...The word serious is defined in the Oxford Shorter Dictionary as being “dealing with or regarding a matter on its grave side, not jesting, trifling or playful; in earnest’ and further ‘weighty, important, grave (of quantity or

degree) considerable’, and ‘attended with danger, and giving cause for anxiety’....”

**104.** He goes on to say:

“Clearly such conduct would not be serious if it was trivial or of momentary effect only at the time of commission or omissions by which the conduct was so defined.”<sup>10</sup>

**105.** Dr Hartley’s unprofessional conduct in relation to his remarks to Ms AA, his commencement of treatment without her consent and his record keeping fall within the category of grave failures of judgment. It was neither trivial nor momentary and is clearly repetitious of conduct for which Dr Hartley has been subject to significant criticism by earlier Panels. His remark about oral rape to Ms AA was offensive and repugnant and definitely gives cause for anxiety about his future treatment of female patients.

**106.** While the Panel acknowledges that Dr Hartley has made some commitment to change, the Panel remains concerned at the extent to which Dr Hartley was prepared to take personal responsibility regarding his conduct at his practice. He frequently used the words “if Ms AA didn’t happen to me” in his characterisation of the complaint.

**107.** The Panel was concerned that such language indicated that Dr Hartley did not see that he was responsible for creating the circumstances in which the complaint was made. Rather he saw himself as a victim of the complainant or of circumstances created by the complainant.

**108.** While many of the matters raised in the allegations concerned matters of dental practice, the principal basis of Ms AA’s complaint was the language used by Dr Hartley in discussing her response to dentists and the failure to obtain consent from her before treating her. The language used by Dr Hartley appears to fall within a pattern of commentary to his female patients with sexual overtones evidenced by both the preceding and current hearings.

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<sup>10</sup> *Parr v Nurses Board of Victoria* (1998) 16 VAR 118

- 109.** Dr Hartley responded to a question from the Panel on this matter and suggested that he used similar language with men and that his use of language is not related to gender. His comments in the past to females have related to their appearance and in this case, his comments place a sexual overtone on a childhood experience. It is perhaps unlikely that Dr Hartley would have made a similar comment to an adult man in similar circumstances.
- 110.** The Panel accepts that Dr Hartley has a longstanding group of clients who hold him in high regard. Nonetheless, it is clear that his behaviour with some female patients may not fall within current mores about appropriate conduct. He himself acknowledged “It's certainly been an awful wake up call for me after 40 years of practice to have three complaints in as many years. I was devastated to say the least.”
- 111.** Previous Panels have expressed concern to Dr Hartley on this issue. A further hearing of similar allegations from a patient of Dr Hartley is likely to lead to significant consequences for the continuation of his practice.
- 112.** The Panel accepted evidence that there had been changes in the management of the practice and that Dr Hartley had more recently invested considerable sums of money, time and effort into ensuring the management of patients and particularly new patients had improved. The new managing systems involved daily meetings, consultation over progress of each patient and weekly meetings have an hour and a half where all the staff are present including my technicians and apprentice technicians, and we talk about anything to do with the practice.
- 113.** He had also taken on a practice manager and appeared to accept that there was a need for change and for increased effort to focus on patients' needs and sensitivities. Dr Hartley told the Panel that he was less isolated from other dentists. He acknowledged his reliance on his staff. He also told the Panel that he was dedicated to his practice and was committed to its improvement.
- 114.** The Panel accepts that Dr Hartley appears to have made a serious commitment to improving his practice and his responses to patients. Accordingly, the Panel, having considered a suspension to enable Dr Hartley to take time to reflect on the issues presented by this hearing has determined to require Dr Hartley to continue to undertake counselling and also to undertake further education and imposes a fine of \$6,000. This is done for the purpose of both specific and general deterrence.

115. In *Ha v Pharmacy Board of Victoria*<sup>11</sup>, His Honour Justice Gillard in referring to the Pharmacy Practice Board stated:

“It is noted that one of the penalties available to the Board is the imposition of a fine. This suggests that there may be an element of punishment involved. But on further reflection, it seems to me that the power of fine is available to inflict a penalty with the purpose of specific deterrence, namely, that it is a reminder not to transgress again. Also, the power of fine may be used to uphold the standing and reputation of the profession by informing the public that the professional body views the conduct seriously.”

116. Justice Gillard also commented, ‘In considering the penalty in the present matter, in my view, there are two prime objectives, namely, the protection of the public and, secondly, to maintain the professional standards of the profession in the eyes of the public.’
117. The level of fine determined by the Panel is intended to serve as a strong reminder to Dr Hartley that he should not transgress in his language or conduct with respect to his female patients again or fail again to comply with the Board’s requirements in respect of record keeping. Record keeping requirements are designed to protect the public by enhancing continuity in dental care and reduce any risks arising from gaps in information.
118. For the reasons referred to in paragraph 74 above, the Panel has also determined to require Dr Hartley to undertake additional training in endodontic treatment of at least one full day with a person authorised by the Board at his expense.
119. The level of fine is also intended to demonstrate to the public that the Panel regards Dr Hartley’s conduct in his treatment of Ms AA with grave disapproval.

**Deborah Foy**  
**Chair**  
**20 May 2008**

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<sup>11</sup> [2002] VSC 322 (14 August 2002)