

# THE DENTAL PRACTICE BOARD OF VICTORIA

## Dr Walter Hohlweg [2007] DPBV 5

### Panel:

Ms Deborah Foy (Chair)

Dr John Boucher

Dr Mandy Leveratt

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

**Counsel for the Practitioner:** Ms G Hubble instructed by DLA Phillips Fox

**Date of Hearing:** 19 February 2007

**Date of Decision:** 12 July 2007

### **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 Hohlweg with respect to allegations contained in paragraphs (a) to (j) of the Notice of Formal Hearing, finds Dr Hohlweg 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.

### **DETERMINATION**

Having considered the matter and having given due weight to the submissions placed before the Panel, the Panel considers it appropriate under section 47(2) of the Act to impose the following penalties:

1. Dr Hohlweg is reprimanded for his conduct;
2. Dr Hohlweg is cautioned with respect to his future conduct; and
3. Dr Hohlweg's registration is subject to a condition that his practice undergoes an audit of infection control practices by a person approved by the Board at regular three monthly intervals for a period of three years. The audit is to assess compliance with the Infection Control Code of Practice. The initial audit to

commence within one month of the determination. The cost of these audits is to be borne by Dr Hohlweg.

4. The results of the audits are to be provided directly to an authorised officer of the Board within two weeks of the audit, and a copy is to be provided to Dr Hohlweg. Dr Hohlweg must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit.
5. Should Dr Hohlweg fail to comply with this condition, his registration will be suspended.

### **Reasons for Decision**

- [1]** The Dental Practice Board of Victoria determined under section 45 of the Act that a Formal Hearing was to be held into the professional conduct of Dr Hohlweg, a registered dental care provider. A Panel was convened and a hearing was held on 19 February 2007.
- [2]** The allegations heard by the Panel are contained in a Notice of Formal Hearing, which described the allegations against Dr Hohlweg.
- [3]** The allegations made against him are as follows:
  - (a) At all material times he has been registered as a dental care provider in Victoria under the *Dental Practice Act 1999* (“the Act”) having first been registered with the Dental Board of Victoria on 30 March 1980.
  - (b) During November/December 2004, 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, and this Code of Practice came into effect on 1 March 2005. This Code of Practice was subsequently reviewed and updated on 13 June 2006, and promulgated on the Board’s website.
  - (c) This Code of Practice together with an accompanying Information Sheet was widely publicised within the dental profession in Victoria, initially being published in the Board’s bulletin in December 2004, and later being posted to all registered dental care providers in Victoria in March 2005 and thereafter by being posted on the Board’s website.

- (d) A copy of the Infection Control Code of Practice number C006 was submitted as an Exhibit.
- (e) 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, Australian Standard AS/NZS 4815:2006 and the Commonwealth Government Publication "Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting" (published January 2004).
- (f) He, being a dentist bound by the Act and maintaining premises in which he practices at 773 Glenferrie Road, Hawthorn ("the premises") are in breach of the Code of Practice.
- (g) He has breached his obligations under paragraph 8 of the Infection Control Code of Practice number C006 in various respects, and particulars of such breaches appear from the document headed "*Practice Inspection Dr Walter Hohlweg, 773 Glenferrie Road, Hawthorn*" dated 22 August 2006 tendered as an Exhibit.
- (h) The notes in the attached document also identify breaches by him of the provisions referred to in those notes of the *Health Records Act 2001*, the *Occupational Health and Safety Act 2004*, the *Drugs Poisons and Controlled Substances Act 1981* (and Regulations 2006), the Infection Control Guidelines publication referred to above and Australian Standard AS/NZS 4815:2006.
- (i) Accordingly, and by this conduct, he has engaged in unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.
- (j) Such unprofessional conduct is of a serious nature.

- [4] On 19 February 2007, the Dental Practice Board of Victoria in a Panel of three members convened to conduct a formal hearing pursuant to the *Dental Practice Act 1999* ("the Act") into the conduct of dentist, Dr Hohlweg. Dr Hohlweg was at all material times a registered dentist.
- [5] The Panel was informed at the outset of the hearing that Dr Hohlweg made a number of admissions with respect to factual matters contained in the Notice of Formal Hearing.
- [6] Dr Hohlweg through his Counsel made full admissions with respect to the allegations and indicated his willingness to undertake training and changes to his practice to comply with the requisite infection control standards.
- [7] On Tuesday 26 August 2006, Dr Hohlweg was interviewed by Dr A Roseman, the Investigative Officer of the Board regarding the infection control practices at his business premises during the course of an inspection of his premises. A complaint had been received which led to the inspection.
- [8] At the completion of the inspection, Dr Roseman prepared a report indicating significant breaches of the Code of Practice together with reports of breaches by Dr Hohlweg of various other provisions of the *Health Records Act (2001)*, the *Occupational Health and Safety Act (2004)*, the *Drugs, Poisons and Controlled Substances Act (1981)*, the Infection Control Guidelines and Australian Standard 4815.
- [9] At the conclusion of Dr Roseman's inspection and his discussions with Dr Hohlweg, Dr Hohlweg voluntarily agreed to close his practice to immediately address some of the breaches of the Code of Practice and meet certain minimum infection control standards.
- [10] Dr Roseman inspected his premises again on 7 September 2006 and it was agreed that Dr Hohlweg could reopen and recommence practice. Dr Hohlweg has been in practice for some 40 years since his training was completed.
- [11] In 2003, Dr Hohlweg had sought advice from Ms Margaret Jennings, a consultant on improvement in infection control procedures generally. Ms Jennings had undertaken a visit to Dr Hohlweg's premises and made some recommendations to him by way of a checklist which was in a developmental phase.

[12] Dr Roseman had access to this checklist.

### **Evidence of Dr Roseman**

[13] Dr Roseman gave evidence regarding the Code of Practice of the Board and its promulgation in December 2004 and its updating in June 2006.

[14] He also gave evidence about his knowledge of Ms Jennings' checklist and how he had used it as an aid in his investigation as part of a process of cross checking. There were a number of matters raised in Ms Jennings' checklist that had not been addressed by Dr Hohlweg. These included:

- a failure to obtain reference material and copies of relevant standards;
- the absence of a protocol for the management of contaminated spills;
- inadequacy of barrier techniques ;
- absence of written protocol for the use of protective gear;
- evidence that Dr Hohlweg was not routinely bagging prior to sterilisation and that the instruments were stored un-bagged.
- inadequate storage of instruments; hand pieces were not processed in pouches and stored on the bench top unprotected from aerosols;
- absence of tracking or protocol for tracking any instruments;
- absence of an effective practice manual;
- instrument processing area was not clean ;
- no heavy duty gloves or eye protection, masks and plastic aprons available for people processing the instruments;
- inappropriate monitoring of the steriliser;
- absence of records of testing and maintenance;
- the autoclave chamber was not clean.

[15] He gave evidence that by the conclusion of his inspection on 22 August 2005 he formed the view that it was appropriate for Dr Hohlweg to cease practice until he had reached at least some basic minimum standards of infection control as he thought that the standards were very deficient in a number of possibly critical areas.

[16] Dr Hohlweg agreed to close his practice until minimum infection control standards had been met.

- [17]** At that time, Dr Roseman's general impression was that Dr Hohlweg did not understand the purpose or application of maintaining a reasonable infection control standard.
- [18]** During the course of Dr Roseman's evidence he played a video of the visit made to Dr Hohlweg's premises.
- [19]** He described a surgery which contained instruments exposed to aerosols, no workflow patterns from clean to contaminated areas, endodontic instruments not properly sterilised, inadequate barrier protection for instruments which had been cleaned, bags used for the sterile storage of instruments at risk of tearing due to the need to constantly search; local anaesthetic cartridges which were out of date, considerable scale in the steriliser chamber, which while working, was overloaded and the tray was dirty. He noted that the steriliser was reaching the required temperature and pressure but whether the steam was adequately penetrating all the instruments was not clear.
- [20]** Dr Roseman gave evidence regarding the purpose of having a nurse to assist the dentist with managing infection control.
- [21]** He also gave evidence that Dr Hohlweg had complied with the minimum requirements for adequate infection control by the time of his second inspection. Dr Hohlweg had undertaken some physical changes in his practice and developed a better workflow. The autoclave had been calibrated and validated at that stage with documentation; it had a printer on the autoclave. He was bagging his instruments more appropriately; the necessary hand pieces were off the top of the bench.
- [22]** He agreed with Counsel for Dr Hohlweg that there were handpieces which did not require bagging after sterilising.
- [23]** Dr Roseman also told the Panel that there was evidence that Dr Hohlweg had tried to introduce certain infection control practices but had not succeeded. He also agreed that a protocol must be derived by applying general rules to specific circumstances of a particular practice.

## **Evidence of Ms Margaret Jennings**

- [24]** Ms Jennings gave evidence that she was an Infection Control Consultant Microbiologist with a degree from RMIT.
- [25]** She commenced her consultancy in 2003/2004 and during the course of 2003, was approached by Dr Hohlweg to undertake some education. She was in the early phase of developing her consultancy work in this. She used a checklist to give herself and the practitioner, some idea of what was required on reading the Board requirements and what she felt that she could deliver.
- [26]** She explained how her checklist was used and the sorts of questions that she would address.
- [27]** She gave evidence that in October 2003 she had attended Dr Hohlweg's practice for approximately two to two and a half hours and believed that she had met him on that occasion. At the end of her visit, she provided Dr Hohlweg with a copy of her checklist.
- [28]** She agreed that she had made some recommendations to Dr Hohlweg which included obtaining some reference material and the adoption of protocols regarding matters such as barriers, improve work flows, and consider expanding instruments for wrapping.
- [29]** Ms Jennings was asked about her impressions of the information contained in photographs taken by Dr Roseman in August 2006 and she replied that she now knew more than she had at the time of her visit to Dr Hohlweg in 2003 and she could see that there were deficiencies in his practices.
- [30]** She conducted two further practice visits, in 2006 and met with Dr Hohlweg and his new nurse. It was her impression that improvements were being made continually, and she gave extra suggestions.
- [31]** She attended Dr Hohlweg's surgery again in January 2007 at the request of his legal advisers.

- [32] Her overall impression at the end of that inspection was that things were moving along. She was concerned that the physical environment of his surgery was perhaps hampering what could be achieved. She also believed that Dr Hohlweg's knowledge had increased. She was however a little disappointed that the protocols still were not in place. She said that Dr Hohlweg and his nurse had given her a commitment to complete the Systematic Operating Procedures Manual (SOP) and that he and his nurse would spend some time each week on the SOP.
- [33] She also commented that she assumed when she visited a practice that while she could probably always make some recommendations that staff are trained from the start. In response to Dr Roseman's observations, she commented Dr Hohlweg had a very small treatment room which also served as an office gave rise to concerns about aerosols.
- [34] At her visit in January 2007, she observed changes. Dr Hohlweg had all the instrument work now done in a room that had been cleared, the carpet had been removed. Dr Hohlweg had acquired an ultrasonic cleaning bath. She also told the Panel that Dr Hohlweg now had a practice manual and made changes with respect to zoning by sheathing handpieces and other equipment. Changes have also been made to retrieval practices.
- [35] Evidence was given that there was better management of water lines and more attention to bagging of items and instruments. Dr Hohlweg had implemented a linear set up for personal protection for staff when processing used items together with the use of a log book.
- [36] She also expressed a view that she thought that Dr Hohlweg might benefit from seeing what people are doing particularly with respect to the use of barrier techniques.

#### **Submissions on behalf of Dr Hohlweg**

- [37] Counsel for Dr Hohlweg submitted that Dr Hohlweg had made significant efforts to improve the infection control practices at his clinic; he had undertaken structural changes to the rooms, improved waterline management, bought new equipment and changed his work practices and that he was ready and willing to make further changes to comply.

- [38]** He also accepted that his knowledge of infection control practices was out of date and needed updating and that regular effort was required not only by his staff but also most certainly from him to improve his knowledge and technique of infection control.
- [39]** He had also accepted that he had not complied with his obligations with the Code of Practice and that this was a serious matter.
- [40]** In mitigation, his Counsel submitted, "Infection control is something that he knows he has to get hold of, get on top of and stay on top of it. There have been difficulties with understanding and there's been difficulties implementing theory into practice, or recommendations into practice."
- [41]** The role of the Panel is to protect the public and ensure the integrity of the professional persons who undertake dental care provision to the public at a standard, which reflects the best evidence of reasonable and safe practice.
- [42]** That is the purpose of the capacity of health practitioner boards to set standards by way of Codes of Practice to both inform and monitor safe health care delivery.
- [43]** The Board requires practitioners to comply with those codes. At the same time, it acknowledges that practitioners do need to apply those Codes to their actual practice.
- [44]** The Board believes that Dr Hohlweg has not applied sufficient attention to these matters in the operation of his practice and that this is a significant failing on his part. However, it recognises that once Dr Hohlweg understood the concerns expressed he voluntarily closed his practice and took immediate steps to improve and meet the minimum standards.
- [45]** The Panel also acknowledges that he has embarked upon significant changes to his practice and to his methods of work and he is to be commended for that.
- [46]** Nonetheless, the Panel has decided to reprimand Dr Hohlweg and caution him with respect to his future practice. A reprimand is a serious matter for a health professional and it is designed to ensure that a professional person takes personal responsibility for the operation of their practice and not rely on other staff to undertake those responsibilities for them.

**[47]** In addition, it has determined that Dr Hohlweg's registration be subject to a condition that his practice undergo an audit of infection control practices at regular three month intervals to assess compliance with the Infection Control Code of Practice by a person approved by the Board and that regular reports are to be provided including a recommendation that if he fails to comply, his registration to be immediately suspended.

**[48]** The Panel was concerned at Dr Hohlweg's failure to complete protocols and standards of practice even though he was well aware of the need to do so as he had been given notice of their importance.

**[49]** The Panel has determined that this condition be applied to his registration to ensure that both Dr Hohlweg and his peers understand the importance of compliance with the Board's Codes of Conduct in order to ensure the safety of their patients and the seriousness of a breach in infection control standards.

**Deborah Foy**  
**Chair**  
**Dated 12 July 2007**