

DENTAL PRACTICE BOARD OF VICTORIA

RE: Dr Michael Lee

[2006] DPBV 4

PANEL:

Mr Victor Harcourt (Chair)
Professor Michael Morgan
Ms Gabrielle MacTiernan

DATE OF HEARING: 16 May 2006

DATE OF DECISION: 16 May 2006

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 24 April 2006 ("the Notice") to be established:

- 1 At all material times Dr Michael Lee has been registered as a dental care provider in Victoria under the Act.
- 2 On 1 March 2005 the Dental Practice Board of Victoria promulgated Code of Practice No.C006, about the practice of dentistry entitled, "Infection Control", under s.69 (1) (e) of the Act.
- 3 At that time and thereafter this Code of Practice was widely publicised within the dental profession in Victoria initially during or about March 2005 by being posted to all registered dental care providers in Victoria and thereafter by being posted on the Board's website. Attached to the notice of hearing is a copy of the infection control Code of Practice No.C006. It is not necessary for that code to be appended to the findings.
- 4 The Code of Practice requires in paragraph 8 that every registered dental care provider must:
 - 4.1 Ensure the premises in which he or she practises are kept in a clean and hygienic state to prevent the spread of infectious disease;
 - 4.2 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
 - 4.3 Act in accordance with the requirements set out in the three documents referred to at paragraph 7 of the Code of Practice, namely, the Practice Manual, AS/NZS4815:2001 and the Commonwealth Government publication "Infection Control Guidelines for Prevention of Transmission of Infectious Diseases in the healthcare setting", published January 2004.
- 5 Dr Lee, being a dentist bound by the Act and maintaining premises in which he practises at 31 Somers Road, Altona, is in breach of the Code of Practice.
- 6 Dr Lee has breached his obligations under paragraph 8 of the Infection Control Code of Practice No.C006 in various respects and particulars of such breaches appear in a document attached to the notice of formal hearing and headed, "Practice Inspection, Dr Michael Lee, 31 Somers Road, Altona". That document was prepared by Dr Roseman and relates to a practice inspection which took place Tuesday, 24 January 2006.

- 7 The notes in the document prepared by Dr Roseman identify breaches by Dr Lee of the provisions referred to in those notes of the *Health Records Act* (2001), the *Health Act* (1958), the *Occupational Health and Safety Act* (2004), the *Drugs Poisons and Controlled Substances Act* (1981), the *Drugs Poisons & Controlled Substances Regulations* (1995), the Infection Control guidelines publication referred to previously in these findings and Australian Standard 4815:2001.
- 8 Accordingly and by his conduct Dr Lee has engaged in unprofessional conduct as defined in section 3 of the *Dental Practice Act* (1999).
- 9 Such unprofessional 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 determinations:

- 1 Dr Lee is fined the sum of \$1,500.00 to be paid by 30 July 2006.
- 2 A condition is to be imposed upon Dr Lee's registration that he submit his practice to an audit every six months to assess Dr Lee's ongoing compliance with his professional obligations concerning infection control in the conduct of his dental care practice. The audit is to be undertaken at the expense of Dr Lee by a person first approved of by an authorised officer of the Board and the nature of the audit must also be first approved by an authorised officer of the Board. These audits are to be conducted for a period of two years from the date of the first audit, which is to be conducted by 15 June 2006. The second, third and fourth audits are to be conducted on a six monthly basis thereafter. 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 Lee. Dr Lee must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit.
- 3 Dr Lee is reprimanded for his conduct, found to be unprofessional conduct of a serious nature.
- 4 Dr Lee is cautioned against a repetition of that conduct and reminded of the need to be assiduous in regard to infection control procedures and to take advantage of all the opportunities which are available to him to ensure that he does not transgress in this regard again.

REASONS

- 5 On 16 May 2006, the Dental Practice Board of Victoria ("the Board") in a panel of three members ("the Panel") convened to conduct a formal hearing pursuant to the *Dental Practice Act* 1999 (Vic) ("the Act") into the conduct of the dental care provider, Dr Michael Lee. Dr Michael Lee was at all material times registered as a dental care provider.
- 6 The Practice Inspection report prepared by Dr Roseman was attached to the notice of formal hearing and substantially admitted by Dr Lee. The Practice Inspection report identifies the following. "That Dr Lee was unable to produce a practice manual or a copy of the Infection Control Guidelines for Prevention of Transmission of Infectious Disease in the Health Care setting published by the Commonwealth Government Department of Health and Aging (2004). There was no evidence of a practice privacy policy. There was no evidence of registration of the X-ray machine. Dr Lee could not produce safety data sheets for any materials used in the practice".
- 7 Dr Roseman in the Practice Inspection report describes the practice as generally unclean and unhygienic. He does note that there had recently been water damage due to a burst

pipe. Dr Roseman then goes on to describe the practice as follows, "In the surgeries and instrument processing area, there's no evidence of appropriate zoning and no protocol for the management of contaminated spills. Barrier techniques were inadequate. There was no protocol for the appropriate management of water lines. Latex gloves were available there were no non latex gloves and there was no sterile gloves present. The hand washing sinks in the surgeries were equipped with wrist taps... Instruments were not routinely bagged prior to sterilisation. Instruments were stored un-bagged in containers which Dr Lee advised were cleaned on an irregular basis. They were not resterilised immediately prior to use. Local anaesthetic was not stored in a locked cupboard. Sharps containers are kept on the floor of the surgery. There were no appropriate protocols for the transfer of instruments and materials within and from the surgery. There was no protocol for the management of needlestick or other work related injuries".

- 8 Dr Roseman goes on to observe that, "The area used for the processing of instruments was untidy and not clean. Work flow patterns were incorrect. There was insufficient personal protection for staff involved in the treatment of used items, i.e. no waterproof apron, mask or eye protection. There was no evidence that instruments were processed in accordance with Australian Standard AS/NZS4815:2001. Dr Lee had no evidence of calibration or validation of the steam sterilizer and no evidence of the use of Class 4, 5 or 6 chemical indicators. There were no records of the testing and maintenance of the steam sterilizer the chamber of which was not clean".
- 9 He also observed that, "The interview with Dr Lee indicated in his opinion that Dr Lee had little knowledge or understanding of the concept of "Standard precautions" or the principles of infection control and the protocols required to maintain a safe practice". The Practice Inspection report then goes on to note that, "At the conclusion of the inspection Dr Lee voluntarily agreed to cease practice immediately until such time as certain minimum standards for infection control had been attained". Those standards were, (1) the autoclave to be calibrated and validated and to have a printer attached. (2) instruments to be processed and stored in accordance with Australian Standard AS/NSZ4815:2001. (3) critical instruments to be tracked. (4), premises to be made clean and hygienic.
- 10 The Panel has had regard to the extensive admissions made by Dr Lee in his affidavit sworn 16 May 2006 and tendered this day. In his affidavit Dr Lee addresses the particulars of the deficiencies in his admissions and also identifies steps which have since been taken to rectify the situation. We note further that Dr Lee engaged Dr Amerena to assist in rectifying the deficiencies at the practice.
- 11 Attached to the affidavit of Dr Lee are two letters from Dr Amerena, the first being dated 2 February 2006 in which Dr Lee is advised about the immediate tasks necessary to establish a minimum level of acceptable infection control procedures. Subsequently Dr Amerena provided a second letter dated 16 February 2006 in which he provides commentary in relation to photographs which he took on the day. If we have a look at some of those comments one of the consistent descriptions used was, "A very dirty state of affairs at the practice". Dr Amerena provided a further report at the request of Dr Lee's solicitors dated 9 May 2006 in which Dr Amerena described Dr Lee's efforts to improve his infection control procedures as significant and very good.
- 12 He identified in his opinion, although it is a matter for this Panel based on the evidence that Dr Lee's surgery at that time was not a threat to the public safety and that he was conscientiously trying to comply with all infection control policies of the Board. And to the extent that the commentary in it discloses an improvement it verifies the conclusion of Dr Amerena which is as follows, and we quote, "Overall Dr Lee has made great progress in his understanding and implementation of infection control procedures. Whilst I have made some suggestions for improvement I would point out that in the many years of inspecting and auditing practices I have never found one in which some recommendations were not necessary".

- 13 Dr Lee's admissions were in all the circumstances appropriate and were taken into account by the Panel in making the determinations. It was considered in the interests of the protection public to ensure ongoing practice inspections took place which would identify any lapse in practice.
- 14 In respect of the fine the Panel considered that it was necessary for there to be specific deterrence in this instance as well as general deterrence in relation to infection control. And we do so in this context. The picture which has been presented to us, is one of neglect and the complete disregard of the importance of infection control to protect the safety of patients. It seems that Dr Lee was and continues to be overwhelmed by the requirements to maintain adequate infection control procedures.
- 15 While Dr Lee retained Dr Amerena to assist in the process we are not convinced that Dr Lee has attempted to rectify all deficiencies in a timely manner. Whatever the reason for this, the Panel is concerned that while Dr Lee may have the intent to improve, that this will occur slowly. While Dr Lee may have improved his infection control procedures sufficiently to have the practice reopened within four weeks, deficiencies still exist as at 16 May, some months after the first visit by Dr Roseman.
- 16 Dr Lee claimed to be a reformed person and that he would maintain proper procedures. We certainly hope that that is the case. Dr Amerena generally gives evidence identifying the improvements but we strongly agree with the comment that Dr Lee requires continuing supervision. And it is for those reasons that we have imposed the determinations. Reference was made by Dr Lee's counsel to the case of *Ha v. Pharmacy Board of Victoria* [2002] VSC 322 in support of the submissions about the extent to which we should take into account the financial circumstances as presented to us of Dr Lee.
- 17 It is worth reiterating that the information which has been provided to us identifies a letter from an accountant dated 1 May 2006 setting out the taxable income for financial years ended 2003, 04 and 05. In paragraph 5 of Dr Lee's affidavit he concludes by stating that his average actual fee income over the last three financial years was \$..... and he also notes that his practice has declined and that he has very few patients. We note the following statements which appear in *Ha* which distinguish it from the present case with what appears to be the more significant evidence as to financial circumstances which were provided in that case as opposed to that which has been provided to the Panel.
- 18 The comments made by the court are at paragraph 120, "A period of suspension is not warranted in the circumstances especially as it could cause his financial ruin. It is unnecessary in the circumstances, his experience and the punishment metered out by the court is a constant reminder not to transgress again." And at paragraph 121, the court refers to the standing of the profession in the community, the Pharmacy Profession, and at paragraph 122, pertinently the court says as follows, "What the court has before it, and which was not before the Board, was evidence concerning the appellant's business and the calamitous and disastrous effect a three month suspension could have on the appellant's business interests. The court has been informed that the probabilities are indeed high that he could not take alternative measures to keep his pharmacy open and his business would fail. Five employees would be out of work and he would be financially ruined. He pays a substantial sum of rent each month together with interest on substantial loans obtained in order to establish his business". At paragraph 123 the court says, "In the final determination for this court to impose an appropriate penalty and giving effect to the twin considerations of public interest and maintenance of the integrity and standing of the profession, it is my opinion that a penalty which does not include suspension would be appropriate". The court then went on and imposed a fine in the amount of \$1500 in respect of that matter.
- 19 Certainly what hasn't been put before this Panel is convincing evidence that a fine of the magnitude which has been imposed would have a calamitous and disastrous effect. In those

circumstances the financial standing of Dr Lee is irrelevant to the determinations of the Panel. It is for these reasons that the Panel has made the determinations.

DATED: 13 June 2006

Victor Harcourt
Chair