DENTAL PRACTICE BOARD OF VICTORIA

RE: Dr Omaima Mostafa

[2004] DPBV 5

PANEL:

Mr Victor Harcourt (Chair)
Dr Anthony Robertson
Ms Gabrielle MacTiernan
Mr Craig McCracken

DATE OF HEARING: 25 October 2004
DATE OF DECISION: 11 November 2004

FINDINGS

The Panel, having considered the evidence and submissions placed before it, and taking into account the admissions, finds the following allegations in the Notice of Formal Hearing under section 45 of the *Dental Practice Act* 1999 dated 26 August 2004 ("the Notice") to be established:

1 At all material times Dr Mostafa has been registered as a dental care provider in Victoria under the *Dental Practice Act* 1999 (Vic).

2 During the period from April 2003 to December 2003, Dr Mostafa provided dental services to two patients:

2.1 Mr A; and

2.2 Mrs B.

Mr A

3 Dr Mostafa provided dental services to Mr A ("the treatment") which included crowns on teeth 12, 11, 21, 22 and 23.

4 Before embarking on the treatment Dr Mostafa failed to obtain proper evidence (radiographs, vitality tests, periodontal analysis) on which to base a diagnosis and treatment plan.

5 Prior to commencing the treatment, Dr Mostafa failed to provide Mr A with all necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed.

6 Dr Mostafa accordingly failed to ensure that her patient understood what treatment he was consenting to, and had the necessary details and information available to him concerning the treatment before he provided any apparent consent.

7 Dr Mostafa accordingly failed to obtain the prior consent (fully and appropriately informed) of Mr A to the treatment being performed.

8 Dr Mostafa prepared and implemented a treatment plan which was compromised and extremely unlikely to produce an acceptable result to Mr A, and did not provide him with sufficient, appropriate information about the deficiencies in the treatment plan.

9 Dr Mostafa failed to take adequate and appropriate steps to properly treat or refer her patient to another practitioner when he presented to her in great pain on 11 August 2003.

10 Further, the dental work which Dr Mostafa provided in regard to the service was:

10.1 extremely poor;

10.2 grossly substandard;

10.3 of a lesser standard than that which the public might reasonably expect of a registered dental care provider; and

10.4 of a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers.

11 Dr Mostafa is guilty of unprofessional conduct of a serious nature by reason of the matters stated in paragraphs 3 to 10 above.

Mrs B

12 Dr Mostafa provided dental services to Mrs B ("the treatment") which included the provision of a ten unit bridge using teeth 16, 15, 25 and 26 as abutments.

13 Before embarking on the treatment Dr Mostafa failed to obtain proper evidence (vitality tests, periodontal analysis, occlusal analysis) on which to base a diagnosis and treatment plan.

14 Prior to commencing the treatment, Dr Mostafa failed to provide Mrs B with all necessary information about the treatment options, advantages, disadvantages, risks and possible complications of the dental treatment proposed; and failed to record any such explanation on her treatment records.

15 Dr Mostafa accordingly failed to ensure that her patient understood what treatment she was consenting to, and had the necessary details and information available to her concerning the treatment before she provided any apparent consent.

16 Dr Mostafa accordingly failed to obtain the prior consent (fully and appropriately informed) of Mrs B to the treatment being performed.

17 Dr Mostafa prepared and implemented a treatment plan which was compromised and extremely unlikely to produce an acceptable result to Mrs B and did not provide her with sufficient, appropriate information about the deficiencies in the treatment plan.

18 After preparing teeth 16, 15, 25, 26 for crowns Dr Mostafa failed to provide adequate temporary restoration thereby causing Mrs B significant and unnecessary pain and discomfort.

19 Dr Mostafa recommended and commenced a treatment plan which was seriously flawed in its design and had minimal prospects of success.

20 In implementing the treatment plan Dr Mostafa prepared teeth 16, 15, 25 and 26 when there was no need to do so, thereby causing permanent and irreparable damage to those teeth.

21 Dr Mostafa failed to refer the patient to appropriate specialists before commencing the treatment and implementing the treatment plan, in circumstances where it was necessary and appropriate for her to do so.

22 Further, the dental work which Dr Mostafa provided in regard to the service was:

22.1 extremely poor;

22.2 grossly substandard;

22.3 of a lesser standard than that which the public might reasonably expect of a registered dental care provider; and

22.4 of a lesser standard than that which might reasonable be expected of a registered dental care provider by his peers.

23 Dr Mostafa is guilty of unprofessional conduct of a serious nature by reason of the matters stated in paragraphs 12 to 22 above.

Infection Control

24 Dr Mostafa, being a Dentist bound by the *Dental Practice Act* 1999, and maintaining premises in which she was practising at 1 Ellerslie Court, Noble Park ("the premises") is in breach of paragraph (b) of the Regulation 401(2) of the *Dentists Regulations* 1992, promulgated under the *Dentists Act* 1972.

25 Regulation 401(2) required Dentists to ensure that:

> "in attending a patient, he or she takes such steps as are practicable to prevent or contain the spread of infectious disease"

26 Those provisions of Regulation 401 have been adopted by the Dental Practice Board (under the *Dental Practice Act* 1999) as an interim Code of Practice applicable to all registered dental care providers.

27 Particulars of the nature of the conduct alleged against Dr Mostafa are that she failed to comply with the publication "*infection control in the health care setting: Guidelines for the Prevention of Transmission of Infectious Diseases"* published by the National Health and Medical Research Council and Australian Standard 4815:2001 entitled *Office-based health care facilities not involved in complex patient procedures and processes - Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of the associated environment*, a copy of which may be obtained from Standards Australia, 9-25 Ralph Street, South Melbourne, telephone number 9693 3500.

28 Further, Dr Mostafa

28.1 failed to implement appropriate and acceptable waste disposal practices and procedures appropriate for the storage and disposal of biomedical waste at her practice premises;

28.2 failed to provide adequate facilities for the welfare of employees at her dental surgeries;

28.3 failed to provide such information, instruction, training and supervision to employees as are necessary to enable them to perform their duties in a manner that is safe and without risks to their health;

28.4 failed to register the x-ray machines installed at her practice premises, and obtain a licence to operate them, as required by Section 108 of the *Health Act* 1958 and the *Radiation Regulations* 1994 Part 3;

28.5 failed to properly store Schedule 4 poisons (as specified in Schedule 4 to the *Drugs, Poisons and Controlled Substances Act* 1981 and the *Drugs, Poisons and Controlled Substances Regulations* 1995) at her practice premises, in that Dr Mostafa failed to store local anaesthetic solution in a lockable cupboard;

28.6 failed to ensure that there were adequate and suitable sterilising equipment and facilities at her practice premises;

28.7 failed to maintain a practice privacy policy as required under the *Health Records Act* 2001;

29 Dr Mostafa is guilty of unprofessional conduct of a serious nature by reason of the matters stated in paragraphs 24 to 28 above.

Advertising

30 Dr Mostafa, being a Dentist bound by the *Dental Practice Act* 1999, and maintaining a premises in which she was practising at 1 Ellerslie Court, Noble Park ("the premises") is in breach of Section 64 of the *Dental Practice Act* 1999.

31 Section 64(1) states that "a person may not advertise a dental care provider's practice or a dental care provider's services in a manner which (a) is or is intended to be false, misleading or deceptive; or …"

32 Particulars of the nature of the conduct alleged against Dr Mostafa are as follows:

32.1 Dr Mostafa's primary dental qualification is Bachelor of Dental Surgery and Medicine from the Alexandria University in Egypt.

32.2 The appropriate and registered abbreviation for that qualification is BDMS.

32.3 On her appointment card, Dr Mostafa has described her qualification as B. D. Sc.

32.4 Dr Mostafa does not have that qualification, and the qualification recorded is therefore false.

32.5 The qualification is also misleading or deceptive, in that it could lead patients to believe that Dr Mostafa holds the qualification Bachelor of Dental Science at an appropriate University, whereas in fact and in truth she does not have that qualification.

32.6 Accordingly, Dr Mostafa was not entitled to record the qualification B. D. Sc, on her appointment cards or elsewhere, and her doing so is false, misleading or deceptive.

33 Dr Mostafa is guilty of unprofessional conduct not of a serious nature by reason of the matters stated in paragraphs 30 to 32 above.

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 *Dental Practice Act* 1999 to impose the following penalty:

1 In respect of the unprofessional conduct of a serious nature relating to Mr A, Dr Mostafa is fined $4,000.00 to be paid by 28 February 2005.

2 In respect of the unprofessional conduct of a serious nature relating to Mrs B, Dr Mostafa is fined $4,000.00 to be paid by 28 February 2005.

3 In respect of the unprofessional conduct of a serious nature relating to the infection control, Dr Mostafa is fined $2,500.00 to be paid by 28 February 2005.

4 The following conditions are imposed upon Dr Mostafa's registration as a dental care provider:

4.1 Dr Mostafa undertake and complete to the satisfaction of the Board the following further education:

4.1.1 Diagnosis and treatment planning and the recording thereof;

4.1.2 Crown and bridge work including diagnosis and treatment planning and the recording thereof;

4.1.3 Informed consent.

The further education specified in subparagraphs 4.1.1 and 4.1.2 must include both clinical and non-clinical components. The duration, content and provider of the education must be first approved by an authorised officer of the Board.

4.2 Satisfactory completion of the further education specified in paragraph 4.1 will be evidenced by the production of a certificate signed by the person responsible for providing the further education to the effect that Dr Mostafa has satisfactorily attended a course designed to provide competency in the diagnosis and treatment planning and the recording thereof, crown and bridge work including diagnosis and treatment planning and the recording thereof and informed consent within the context of dental care provided by a general dental practitioner and that Dr Mostafa has demonstrated a competency equivalent to the standard of a newly graduating final year student.

4.3 The further education is to be undertaken by 30 June 2005 and is to be at the expense of Dr Mostafa. This education is not to be considered as being in satisfaction of Dr Mostafa's continuing professional development requirements or any part of it for the period ending 31 December 2006.

4.4 Dr Mostafa is not to practise in the area of crown and bridge work until she has satisfactorily completed the further education specified in subparagraphs 4.1.1, 4.1.2 and 4.1.3. To the extent that it is necessary to practise in these areas to complete the clinical components of the said further education, Dr Mostafa may so practise provided that it is under the direct supervision of the person providing the further education.

4.5 Dr Mostafa submit her practice to an audit every six months to assess ongoing compliance with her professional obligations concerning infection control and the related matters referred to in paragraph 28 of the Findings in the conduct of her dental care practice.

4.5.1 The audit is to be undertaken at Dr Mostafa's expense 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.

4.5.2 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 31 January 2005. The second and third audits are to be conducted by 31 December 2005 and 31 December 2006 respectively.

4.5.3 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 Mostafa.

4.5.4 Dr Mostafa 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 If Dr Mostafa fails to pay the fines or comply with any of the conditions imposed upon her registration by the due dates, Dr Mostafa's registration as a dental care provider is suspended from the date of non-compliance until the date of compliance.

6 The Panel reprimands Dr Mostafa for her conduct found to be unprofessional conduct of a serious nature.

7 The Panel also cautions Dr Mostafa against a repetition of her conduct found to be unprofessional conduct not of a serious nature.

REASONS

1 On 25 October 2004, the Dental Practice Board of Victoria ("the Board") in a panel of four members ("the Panel") convened to conduct a formal hearing pursuant to the *Dental Practice Act* 1999 (Vic) ("the Act") into the conduct of the dentist, Dr Omaima Mostafa. Dr Mostafa was at all material times a registered dentist.

Allegations

2 The formal hearing concerned the following allegations placed before Dr Mostafa in a Notice of Formal Hearing dated 26 August 2004:

> "(a) At all material times, you have been registered as a dental care provider in Victoria under the Act;
>
> (b) During the period from April 2003 to December 2003, you provided dental services to two patients:
>
> (i) Mr A;
>
> (ii) Mrs B.
>
> **Mr A**
>
> (c) You provided dental services to Mr A ("the treatment") which included crowns on teeth 12, 11, 21, 22 and 23.
>
> (d) Before embarking on the treatment you failed to obtain proper evidence (radiographs, vitality tests, periodontal analysis) on which to base a diagnosis and treatment plan.
>
> (e) Prior to commencing the treatment, you failed to provide Mr A with all necessary information about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed.
>
> (f) You accordingly failed to ensure that your patient understood what treatment he was consenting to, and had the necessary details and information available to him concerning the treatment before he provided any apparent consent.
>
> (g) You accordingly failed to obtain the prior consent (fully and appropriately informed) of Mr A to the treatment being performed.

(h) You prepared and implemented a treatment plan which was compromised and extremely unlikely to produce an acceptable result to M A, and did not provide him with sufficient, appropriate information about the deficiencies in the treatment plan.

(i) You failed to take adequate and appropriate steps to properly treat or refer your patient to another practitioner when he presented to you in great pain on 11 August 2003.

(j) Further, the dental work which you provided in regard to the service was:

i) extremely poor;

ii) grossly substandard;

iii) of a lesser standard than that which the public might reasonably expect of a registered dental care provider; and

iv) of a lesser standard than that which might reasonably be expected of a registered dental care provider by his peers.

(k) Accordingly, in providing these services, you have engaged in unprofessional conduct of a serious nature.

Mrs B

(l) You provided dental services to Mrs B ("the treatment"), which included the provision of a ten unit bridge using teeth 16, 15, 25 and 26 as abutments.

(m) Before embarking on the treatment you failed to obtain proper evidence (vitality tests, periodontal analysis, occlusal analysis) on which to base a diagnosis and treatment plan.

(n) Prior to commencing the treatment, you failed to provide Mrs B with all necessary information about the treatment options, advantages, disadvantages, risks and possible complications of the dental treatment proposed; and failed to record any such explanation on your treatment records.

(o) 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 the treatment before she provided any apparent consent.

(p) You accordingly failed to obtain the prior consent (fully and appropriately informed) of Mrs B to the treatment being performed.

(q) You prepared and implemented a treatment plan which was compromised and extremely unlikely to produce an acceptable result to Mrs B and did not provide her with sufficient,

appropriate information about the deficiencies in the treatment plan.

(r) After preparing teeth 16, 15, 25, 26 for crowns you failed to provide adequate temporary restoration thereby causing Mrs B significant and unnecessary pain and discomfort.

(s) You recommenced and commenced a treatment plan which was seriously flawed in its design and had minimal prospects of success.

(t) In implementing the treatment plan you prepared teeth 16, 15, 25 and 26 when there was no need to do so, thereby causing permanent and irreparable damage to those teeth.

(u) You failed to refer the patient to appropriate specialists before commencing the treatment and implementing the treatment plan, in circumstances where it was necessary and appropriate for you to do so.

(v) Further, the dental work which you provided in regard to the service 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 reasonable be expected of a registered dental care provider by his peers.

(w) Accordingly, in providing these services, you have engaged in unprofessional conduct of a serious nature.

Infection Control

(x) You, being a Dentist bound by the *Dental Practice Act* 1999, and maintaining premises in which you were practising at 1 Ellerslie Court, Noble Park ("the premises") are in breach of paragraph (b) of the Regulation 401(2) of the *Dentists Regulations* 1992, promulgated under the *Dentists Act* 1972.

(y) Regulation 401(2) required Dentists to ensure that:

> "in attending a patient, he or she takes such steps as are practicable to prevent or contain the spread of infectious disease"

(z) Those provisions of Regulation 401 have been adopted by the Dental Practice Board (under the *Dental Practice Act* 1999) as an interim Code of Practice applicable to all registered dental care providers.

(aa) Particulars of the nature of the conduct alleged against you are that you failed to comply with the publication "*infection control in the health care setting: Guidelines for the Prevention of Transmission of Infectious Diseases"* published by the National Health and Medical Research Council and Australian Standard 4815:2001 entitled *Office-based health care facilities not involved in complex patient procedures and processes - Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of the associated environment*, a copy of which may be obtained from Standards Australia, 9-25 Ralph Street, South Melbourne, telephone number 9693 3500.

(bb) You have accordingly been guilty of unprofessional conduct of a serious nature as defined in Section 3 of the *Dental Practice Act* 1999.

(cc) In addition, that you, being a Dentist bound by the *Dental Practice Act* 1999, have been guilty of unprofessional conduct of a serious nature and in particular that you:

i) failed to implement appropriate and acceptable waste disposal practices and procedures appropriate for the storage and disposal of biomedical waste at your practice premises;

ii) failed to provide adequate facilities for the welfare of employees at your dental surgeries;

iii) failed to provide such information, instruction, training and supervision to employees as are necessary to enable them to perform their duties in a manner that is safe and without risks to their health;

iv) failed to register the x-ray machines installed at your practice premises, and obtain a licence to operate them, as required by Section 108 of the *Health Act* 1958 and the *Radiation Regulations* 1994 Part 3;

v) failed to properly store Schedule 4 poisons (as specified in Schedule 4 to the *Drugs, Poisons and Controlled Substances Act* 1981 and the *Drugs, Poisons and Controlled Substances Regulations* 1995) at your practice premises, in that you failed to store local anaesthetic solution in a lockable cupboard;

vi) failed to ensure that there were adequate and suitable sterilising equipment and facilities at your practice premises;

vii) failed to maintain a practice privacy policy as required under the *Health Records Act* 2001;

viii) you have accordingly, engaged in unprofessional conduct of a serious nature.

Advertising

(dd) You, being a Dentist bound by the *Dental Practice Act* 1999, and maintaining a premises in which you were practising at 1 Ellerslie Court, Noble Park ("the premises") is in breach of Section 64 of the *Dental Practice Act* 1999.

(ee) Section 64(1) states that "a person may not advertise a dental care provider's practice or a dental care provider's services in a manner which (a) is or is intended to be false, misleading or deceptive; or …"

(ff) Particulars of the nature of the conduct alleged against you are as follows:

i) Your primary dental qualification is Bachelor of Dental Surgery and Medicine from the Alexandria University in Egypt.

ii) The appropriate and registered abbreviation for that qualification is BDMS.

iii) On your appointment card, you have described your qualification as B. D. Sc.

iv) You do not have that qualification, and the qualification recorded is therefore false.

v) The qualification is also misleading or deceptive, in that it could lead patients to believe that you hold the qualification Bachelor of Dental Science at an appropriate University, whereas in fact and in truth you do not have that qualification.

vi) Accordingly, you were not entitled to record the qualification B. D. Sc, on your appointment cards or elsewhere, and your doing so is false, misleading or deceptive.

(gg) You have accordingly engaged in unprofessional conduct of a serious nature."

Further Particulars

3 Prior to the commencement of the hearing Dr Mostafa, through her solicitors, sought further and better particulars of allegations made in the Notice of Formal Hearing, in particular, in respect of paragraphs (e), (h), (n), (q), (s), (t) and (cc). By letter dated 29 September 2004 Counsel assisting the Panel provided the following further and better particulars:

"1 <u>As to paragraph (e):</u>

a) By way of general response to this request, you are referred to the report of Dr C dated 20 September 2003 (document E10 at page 179 of the Board folder) for its full terms and effect;

b) By way of further response, the following risks and possible complications should have been explained to Mr A prior to commencement of the dental treatment: -

- the fact that Mr A had occlusal and bite collapse (resulting in a reduction in vertical dimension and tooth rotation/super-eruption), which led to a particular risk that the Treatment Plan would fail due to extreme stress and strain being placed on anterior teeth;
- the fact that Mr A's teeth had been compromised by earlier root canal therapy on teeth 12, 21, 22 and 23;
- the fact that Mr A's teeth were compromised by dental caries;
- the fact that Mr A's teeth were compromised by extensive loss of tooth structure;
- the fact that Mr A had previous defective root canal therapy on teeth 12, 22 and 23;
- the fact that there were periapical areas on his teeth 12, 11, 21, 22 and 23, indicating the presence of infection; and
- the fact that the combination of all of these factors created the very substantial risk that the Treatment Plan would almost certainly fail.

2 <u>As to paragraph (h):</u>

a) A combined answer can be given to sub-paragraphs (i) and (ii) of this request;

b) The Treatment Plan for Mr A was compromised and extremely unlikely to produce an acceptable result because: -

- Dr Mostafa failed to conduct a proper initial examination, assessment and diagnosis of Mr A's dentition;
- Dr Mostafa failed to detect serious underlying problems in that respect which substantially compromised her Treatment Plan to provide five crowns on severely compromised teeth;
- the lack of an initial proper dental examination (including radiographs, vitality tests, periodontal analysis and occlusal analysis) was such that it failed to reveal the true state of the teeth being treated;

- accordingly, taking account of all of these matters, the Treatment Plan was compromised and extremely unlikely to produce an acceptable result.

3 As to paragraph (n):

a) By way of general response to this request, you are referred to the letter from Dr D to Dr E dated 28 November 2003 and to Dr D's report to the Dental Practice Board of Victoria dated 23 March 2004 (documents F10 and F12 at pages 213 to 216 of the Board folder) for their full terms and effect;

b) By way of further response, the following risks and possible complications should have been explained to Mrs B prior to commencement of the Dental Treatment:-

- she had a Class 2 skeletal and dental pattern that produced a clinical situation in which there is deep overbite, which produces unfavourable loading of the pontics during occlusal excursive movements;

- the overjet necessary to support her lip would necessitate gross bulk in the pontic area;

- the proposed bridge would extend across the arch and would be without anterior support, ie there would be insufficient or no anterior support for the bridge;

- the leverage on the pontic area during function and parafunction would lead to the leaking of the margins of the abutment teeth; and

- the length of the proposed bridge span around the arch would lead to porcelain failure.

c) In the light of these risks and possible complications, Mrs B should have received a strong recommendation not to proceed with the proposed Treatment Plan, but rather to proceed with a new precision fitted removable partial denture (RPD) or dental implants. She should have been informed that fixed bridgework supported on the prepared teeth was not a feasible or reasonable option for her dental treatment.

4 As to paragraph (q):

a) A combined answer can be given to sub-paragraphs (i) and (ii) of this request;

b) The Treatment Plan for Mrs B was compromised and extremely unlikely to produce an acceptable result because:

- Dr Mostafa failed to take the factors referred to in paragraph 3 above into account in deciding upon an appropriate Treatment Plan;

- Dr Mostafa should rather have adopted a Treatment Plan involving placing a new precision fitted RPD or dental implants, because fixed bridge work supported on the prepared teeth was not a feasible or reasonable option for the dental treatment of Mrs B.

5 As to paragraph (s):

a) You are referred to paragraph 4 above, and the letter and report of Dr D referred to in paragraph 3(a) above;

b) For the reasons given there, the proposed Treatment Plan involving fixed bridgework was flawed and had minimal prospects of success, and was not a feasible or reasonable option for the dental treatment of Mrs B.

6 As to paragraph (f):

a) Dr Mostafa prepared teeth 16, 15, 25 and 26 as part of her flawed Treatment Plan, because she intended to place crowns on those teeth to support the ten unit bridge;

b) That Treatment Plan was flawed, compromised and extremely unlikely to produce an acceptable result;

c) Dr Mostafa should rather have followed a Treatment Plan involving placing a new precision fitted RPD or dental implants;

d) If she had done so, it would not have been necessary for her to prepare all of these teeth (16,15, 25 and 26) for crowns.

7 As to paragraph (cc):

a) By way of general response to this request, you are referred to the Practice Inspection report of Dr Roseman dated the 15th of January 2004 and the transcript of the interview conducted by Dr Roseman with Dr Mostafa on 14 January 2004 (documents G1 and G2 at pages 219 to 235 of the Board folder) for their full terms and effect;

b) By way of further response, Dr Mostafa failed to provide adequate facilities for the welfare of her employees in the following respects -

- Dr Mostafa did not have safety data sheets for any materials used in the practice;

- the sharps container was on the floor in the "*laundry*" and sharps were not disposed of at the point of use;

- 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;

- the sterilising room (laundry) was untidy and not clean;

- work flow patterns were incorrect;

- there was insufficient personal protection for staff involved in the treatment of used items ie no waterproof apron masks or eye protection.

c) By way of further response, Dr Mostafa failed to provide such information, instruction, training and supervision to employees as are necessary to enable them to perform their duties in a manner that is safe and without risk to their health in the following respects:-

- she did not have a copy of the NH & MRC Guidelines (on infection control) available for her staff;

- she did not have a copy of Australian Standard 4815 available for her staff;

- she had not arranged any update training for her staff for infection control for the last five years;

- she did not have available for her staff safety data sheets for the materials used in the practice;

- she did not have available for her staff appropriate protocols for the transfer of instruments and materials within and from the surgery; and

- she did not have available for her staff any protocol for the management of needlestick or other work related injuries."

Admissions

4 The Panel was informed at the outset of the hearing that Dr Mostafa made a number of admissions. Initially, counsel for Dr Mostafa had informed counsel assisting the Panel that paragraphs (a), (b), (c) and (l) of the Notice were admitted but foreshadowed further admissions being made. An affidavit sworn by Dr Mostafa on 22 October 2004 was tendered to the Panel and it contained further admissions. During the course of the morning of the first day of hearing, Dr Mostafa, through her counsel, admitted most of the substantive allegations notwithstanding that certain of the detail of the evidence to be given by the patients was disputed by Dr Mostafa.

5 Dr Mostafa admitted that the dental work she provided to the Patients was inadequate, leaving it to the Panel to make a finding as to whether it could be characterised in the terms

set out in the Notice. Based upon the evidence before the Panel it was certainly satisfied that the dental work was of a lesser standard than that which either the public or Dr Mostafa's peers in the dental profession might reasonably expect of a registered dental care provider, and could be considered extremely poor and grossly substandard.

6 Dr Mostafa also admitted, in respect of the allegations relating to advertising (paragraphs (dd)-(ff)) that she had engaged in unprofessional conduct not of a serious nature. It was not contended with any vigour by counsel assisting the Panel that the unprofessional conduct in this regard should be characterised as being of a serious nature.

7 It should also be noted that Dr Mostafa made certain admissions concerning the receipt of certain documents which need not be detailed in these Reasons. Dr Mostafa admitted the correspondence and reports of Dr C, Dr D, Dr F and Dr E. Dr Mostafa further admitted the further allegations made in the further and better particulars provided by counsel assisting the Panel save for dot points one and three in paragraph 1(b).

8 Dr Mostafa, through her counsel, submitted that, in respect of the Determinations which could be made by the Panel, that it was appropriate that she receive a reprimand and that certain conditions be placed upon her registration. These conditions related to attending an approved course covering diagnosis and treatment planning and the implementation of crown and bridge treatment, submitting her practice to six-monthly audits for a period of two years, seeking approval of a special prosthodontist for any treatment plan involving a bridge over four or more units.

9 Based upon the admissions of Dr Mostafa and the evidence before it, the Panel has made findings consistent with the admissions made by Dr Mostafa. The Panel records its appreciation of Dr Mostafa's admissions. These admissions assisted in the conduct of the hearing and were taken into account by the Panel in making the Findings and Determinations which have been made, and to Dr Mostafa's benefit.

Findings and Determination of the Panel

10 The *Dental Practice Act* 1999 states that its main purposes, inter alia, are :

> "(a) to provide for the registration of dental care providers and investigations into the professional conduct and fitness to practise of registered dental care providers; and
>
> (b) to regulate the provision of dental care services; and …" (section 1).

11 The functions of the Dental Practice Board of Victoria established pursuant to the Act are broad and give effect to the main purposes of the Act (section 69). It is well accepted that the Board and indeed any Panel appointed under section 43 of the Act for a formal hearing, must have regard to the objective of the Act which is the protection of the public. This is particularly pertinent to a formal hearing into the professional conduct of a registered dental care provider which inquires into whether the dental care provider has or has not engaged in unprofessional conduct either of a serious nature or not of a serious nature.

12 A finding by a Panel that a dental care provider has engaged in unprofessional conduct of a serious nature or not of a serious nature may result in certain determinations being made which may be seen to be disciplinary in their nature. Again, however, the determinations are made for the protection of the public:

> "The Tribunal referred to the effect of the criminal and disciplinary proceedings on the doctor and their costs 'in money and emotional stress'. These matters would be highly relevant if the purpose of these proceedings

was punitive, but their purpose is entirely protective. In Clyne v New South Wales Bar Association (1960) 104186 at 201-202, the court said:

> " … Although it is sometimes referred to as 'the penalty of disbarment' it must be emphasised that a disbarring order is in no sense punitive in character. When such an order is made, it is made, from the public point of view, for the protection of those who require protection, and from the professional point of view, in order that abuse of privilege may not lead to loss of privilege."

"Later, in New South Wales Bar Association v Evatt (at 183-184), the court said:

> "… 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."[1]

13 Unprofessional conduct of a serious nature is not specifically defined. Assistance can be found in certain authorities, in particular, *Parr v Nurses Board of Victoria* (unreported, VCAT, 2 December 1998) in which Kellam J indicated that whether a nurse had engaged in unprofessional conduct of a serious nature must depend on the facts of the case. He also said:

> "Clearly such conduct would not be serious if it was trivial, or of momentary effect only at the time of the commission or omission by which the conduct was so defined. It must be a departure, in a substantial manner, from the standards which might be reasonably expected of a registered nurse. The departure from such standards must be blameworthy and deserving of more than passing censure."

14 Referring to Kellam J's decision, Ashley J in the Victorian Supreme Court stated:

> "There is always a question whether it is best to let the language of legislation - particularly where the language involves words in everyday usage - speak for itself; or rather seek to clothe it with meaning by recourse to other language. Bearing in mind that the particular language needs to be applied, if not often then at least not infrequently, by bodies consisting either wholly or in the main of non-lawyers, His Honour's analysis should be seen - bearing in mind always that it was tailored to the circumstance of the case before him - as an accurate and useful guide to the application of that legislation."[2]

15 In *Gee v General Medical Council*[3] comment was made that continuing acts of unprofessional conduct may be a factor in determining whether it is serious or not:

> "Professional misconduct on a single occasion such as a failure to make a record of treatment for charging purposes might not amount to serious professional misconduct and yet if such failure were persisted in this might make the failures amount to serious professional misconduct: see, for example, *Felix v General Dental Council* [1960] ACT 704,721.[4]"

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[1] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630, 637 to 638. See also *Reyes v Dental Board of South Australia* [2002] SASC 239, paragraph 32.
[2] *Domburg v Nurses Board of Victoria* [2000] VSC 369 at [59].
[3] *Gee v General Medical Council* [1987] 2 All ER 193.
[4] *Gee v General Medical Council* [1987] 2 All ER 193,198.

16 Dr Mostafa conceded that she had been guilty of unprofessional conduct of a serious nature in the terms set out in the Findings. It was therefore not necessary for the Panel to examine at length the evidence to reach such a finding. The Panel was however satisfied that the admissions were appropriate.

17 Counsel for Dr Mostafa submitted that the appropriate penalty was a reprimand and for conditions to be applied to her practice. Dr Mostafa had indicated in the affidavit tendered to the Panel her acceptance of the desirability of having further education with regard to crown and bridge work and her intention to seek specialist assistance with respect to complex crown and bridge cases.

18 Counsel then referred the Panel to the decision in *SRNA v The Medical Board of Western Australia* [2004] WASCA 198 (27 August 2004). In particular, the Panel was referred to the discussion about penalties which had been imposed by the Medical Board in Western Australia in cases of gross carelessness. The point highlighted by counsel was that of the 13 cases which were identified, there were no suspensions in ten of the cases, the others were a combination of a reprimand with conditions and perhaps a fine. Counsel suggested that this was an indication of a set of parameters that have been approved by a superior court which were applicable in the present case.

19 Turning to the specifics of the case, counsel for Dr Mostafa conceded that the prosthodontic treatment offered by the dentist exceeded her level of competence and that the outcomes were sub-optimal. The admissions made by Dr Mostafa reflected an understanding on her part of the inadequacies in her past practice and her understanding of the need for reform of her practice and to ensure that these matters would not reoccur, it was submitted. Further, Dr Mostafa had indicated a willingness to solve the deficiencies in her practice as evidenced by her response to the infection control issues which had been identified.

20 It was also submitted that Dr Mostafa's errors were made from a lack of well-informed thought rather than simply from a lack of thought, and that the consequences for the patients were relatively modest.

21 Counsel then turned to the question of a fine and while the primary submission was that one should not be imposed, made submissions concerning the financial factors to be taken into account if a fine was to be considered.

22 In addition to making general submissions concerning the quality of the work performed by Dr Mostafa, counsel assisting the Panel made brief submissions concerning the Determinations. It was submitted that Dr Mostafa should be directed to undertake training in the areas of diagnosis and crown and bridge work. Further, that Dr Mostafa not practise in the area of crown and bridge work until she had completed a course of such training to the satisfaction of the Board, and that there be a system of infection control of audits.

23 After a consideration of all of the evidence and the submissions, the Panel considered that it was appropriate, particularly in light of the concessions, that Dr Mostafa undertake further education in the areas of:

23.1 Diagnosis and treatment planning and the recording thereof;

23.2 Crown and bridge work including diagnosis and treatment planning and the recording thereof; and

23.3 informed consent.

24 Until such time as Dr Mostafa has undertaken the education It was considered appropriate that Dr Mostafa not practise in the areas of crown and bridge work. It was recognised that to satisfy the clinical components of the further education, Dr Mostafa could undertake crown and bridge work provided it was under the direct supervision of the educator.

25 In relation to the infection control matters, and given the serious departure from the standards expected of a registered dental provider, the Panel considered it appropriate for there to be audits to be conducted every six months until 31 December 2006. This is consistent with the approach which has been adopted by the Board in recent matters and ensures the protection of the public is achieved by ensuring ongoing monitoring and compliance.

26 Appropriate with the seriousness of Dr Mostafa's unprofessional conduct, the Panel considered it appropriate to impose fines and a reprimand. While the Panel was satisfied that there was not a significant risk of Dr Mostafa re-offending, it was appropriate to take into account the specific and general deterrence effect of the Determinations imposed by the Panel. While it was submitted by counsel on behalf of Dr Mostafa that her treatment of the patients demonstrated a lack of informed thought, it was also considered by the Panel that it demonstrated a lack of insight into the limitations of her own skills and competencies.

27 This lack of insight placed at risk the public and in particular the patients the subject of the complaint. Dr Mostafa's breach of the infection control standards also placed at risk members of the public attending her practice as her patients. Practitioners need to be acutely aware of their own levels of competence and not place their patients at risk by recommending, commencing and implementing a treatment plan which requires skills beyond that which the dental care provider has.

28 In the present case, it was submitted that the consequences for the patients were relatively modest. Whether that is indeed a true characterisation of the consequences, for each of the patients it was clear that the outcomes were perceived by them to be much more serious.

29 Notwithstanding the above, the Panel did not consider this was a matter appropriate for either the suspension or cancellation of the registration of Dr Mostafa. Dr Mostafa's response to the complaints, her willingness to rectify her practices and the approach to this hearing which indicated a realisation about her own shortcomings were taken into account by the Panel in the Determinations which have been made.

Dated: 10 December 2004

Victor Harcourt
Chair