DENTAL PRACTICE BOARD OF VICTORIA

RE: Dr Hoang (Peter) Nguyen

[2005] DPBV 7

PANEL:

Mr Victor Harcourt (Chair)
Dr Mandy Leveratt
Dr Gerard Condon

DATE OF HEARING: 27 June 2005
DATE OF DECISION: 27 June 2005

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 20 April 2005 ("the Notice") to be established:

1. At all material times Dr Hoang Nguyen was registered as a dental care provider in Victoria under the *Dental Practice Act* 1999.

2. Dr Nguyen provided dental services ("the Services") to his patient, Ms A on 9 February 2004 and 1 March 2004. Dr Nguyen's patient card in relation to the notes recorded by him of the Services was attached to the Notice.

3. In the course of providing the Services, Dr Nguyen diagnosed Ms A with temporo-mandibular joint disorder symptoms and recommended a treatment plan involving the insertion of a permanent device known as a MARA Appliance (Mandibular Advancement Repositioning Appliance) in her mouth with the aim of repositioning her jaw and the condyles down and forward into a more favourable position so as to relieve the pressure on the TM joint in an effort to reduce the signs and symptoms of the patient's diagnosed TMJ dysfunction.

4. Prior to commencing that treatment, Dr Nguyen failed to provide Ms A with all necessary information (both orally and by way of appropriate documentation) about the treatment options, the likely outcomes, advantages, disadvantages, risks and possible complications of the dental treatment proposed (namely, the insertion of the MARA Appliance).

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

6. Dr Nguyen accordingly failed to obtain the prior consent (fully and appropriately informed) of Ms A to the dental treatment being performed.

7. Dr Nguyen failed to maintain adequate and appropriate dental records relating to the information which he provided to Ms A about the Services and the apparent consent which she provided to Dr Nguyen in relation to the Services.

8. Further, Dr Nguyen's dental records do not contain any instructions given by him to the laboratory, and they also contain erasures/deletions, all of which are inappropriate and contrary to the Board's Code of Practice on Dental Records (C003).

9 Dr Nguyen prepared and implemented a treatment plan which was flawed in its conception, not appropriate to Ms A's condition and would not produce an acceptable result to Ms A, and did not provide her with sufficient, appropriate information about the deficiencies in that treatment plan.

10 Dr Nguyen failed to refer the matter to a specialist practitioner dealing with temporo-mandibular joint dysfunction prior to commencing treatment, in circumstances where it was necessary and appropriate for him to do so.

11 Further, in both his diagnosis and in devising and implementing his treatment plan, the dental work which Dr Nguyen provided in regard to the Services was:

11.1 extremely poor;

11.2 grossly substandard;

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

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

12 As a result of the dental work which Dr Nguyen provided to the patient, she endured significant pain and suffering and it was necessary to have the MARA Appliance removed urgently.

13 As a further result of the poor standard of dental work which Dr Nguyen provided to the patient, she has suffered severe damage to her teeth inter alia as a result of the "enamel stripping" which Dr Nguyen performed to fit the appliance, with the result that a number of her teeth will require full coverage crowns (which could themselves compromise the patient's future dental health).

14 Accordingly, in all of these respects, in providing the Services, Dr Nguyen engaged in unprofessional conduct.

15 Such unprofessional conduct was of a serious nature.

16 Further, the patient complained to Dr Nguyen on the day after the MARA Appliance was inserted, and again thereafter, about the pain and excessive discomfort that she was experiencing as a result of the Appliance.

17 Dr Nguyen responded to those complaints entirely inappropriately, by simply seeking to reassure the patient over the phone that the Appliance was not too large for her mouth and that her pain was normal and temporary, when he should have called the patient immediately into his surgery for an examination and check-up, so as to ensure that the MARA Appliance had been inserted and fitted correctly and appropriately.

18 In acting in this way, Dr Nguyen engaged in unprofessional conduct.

19 Such unprofessional conduct was 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 *Dental Practice Act* 1999 to impose the following determinations:

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

1.1 Dr Nguyen submit his practice to a general practice audit to assess compliance with his professional obligations in the conduct of his dental care practice. The audit will include an examination of, but is not limited to the following: diagnosis and treatment planning; informed consent; record keeping; and clinical procedures and outcomes.

1.2 The general practice audits are to be conducted for a period of two years from the date of the first audit, which is to be conducted by 1 August 2005. The audits are to take place every three months for the first year and every six months for the second year.

1.3 The results of the general practice audits are to be provided directly to the CEO of the Board within two weeks of the audit and a copy is to be provided to Dr Nguyen. Dr Nguyen must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit.

1.4 The general practice audits are to be undertaken at Dr Nguyen's expense by a person first approved of by the CEO of the Board and the nature of the general practice audits must also be first approved by the CEO.

2 Dr Nguyen is cautioned against a repetition of his unprofessional conduct and that he reflect upon the general practice audits as an opportunity to learn, to improve his clinical outcomes in the conduct of his practice and to regain his confidence and skill in the conduct of his general practice.

REASONS

1 On 27 June 2005, 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 Hoang Nguyen. Dr Hoang Nguyen was at all material times a registered dental care provider.

2 Dr Nguyen's conduct in this matter serves as a salutary reminder to all registered dental care providers not to be over-confident in the use of information gained from seminars and other educational activities as the following passage of evidence given by Dr Nguyen demonstrates:

> "… I felt really bad you know what I've done for Ms A and I can't say anything more than I'm really sorry for it and if ever this case come up again, I will refer, and I try not to - because I always, I mean with the seminar I went to and they seemed to make complex cases seem simple and I thought I can help and I was wrong. Overall it is - I just feel really sad about it, and I'm sorry for the whole lot.
>
> "Dr Nguyen you've indicated that the seminar made it seem a good thing to do but you now realise it was a bad thing to do and you feel very sorry for the patient and the discomfort she experienced. What have you done in respect of your practice to change your procedures so that the Panel can be sure that an incident like Ms A or an incident like the patient in the 2004

> formal hearing, doesn't happen again? How can the Panel be sure that you are not going to embark on some very ambitious orthodontic work or prosthodontic work and cause problems for another patient in the future? - - - I try to work within the skills I have and if I suspect something complicated I will refer the patient to specialists."[1]

3 It is important to note at the outset that Dr Nguyen approached this formal hearing admitting all but perhaps one of the allegations upon which the Panel has now made findings. Dr Nguyen was frank and open in the admissions which he made and did not seek to avoid taking responsibility for the mistakes which he had made.

4 Dr Nguyen also made a number of apologies for his conduct. He did so in evidence provided to the Panel and in an affidavit which was tendered during the course of the hearing. In this matter, the patient was not present during the hearing and it is not known to the Panel whether she has been made aware of the apologies made by Dr Nguyen. For the purposes of this record, we shall set out some of those apologies but we would recommend that Dr Nguyen communicate with his patient to ensure that she is fully aware of the extent of his admissions and the remorse he has felt for his conduct which has left the patient in a worse position than when she first consulted with Dr Nguyen.

5 In his affidavit, Dr Nguyen made the following apologies:

- "20 … If Ms A felt that I was too rough in performing the cleaning, I am very sorry and in the future I will concentrate on ensuring that my patients do not feel any unnecessary pressure during this procedure."
- "25 … The reason I recommended the M.A.R.A appliance was that after attending Dr Rondeau's course I honestly believed it could help Ms A with her headaches. I thought that my treatment plan has reasonable prospects of success. In hindsight I now know that I chose the wrong treatment for Ms A, which I regret very much."
- "26 … However, now that I realise the treatment plan was inappropriate I accept that I could not have given Ms A all of the information (about the risks and disadvantages) that she would need to make a decision about whether or not to proceed with the treatment."
- "31 … I regret that I attempted to use the appliance to address what I thought were TMJ symptoms in Ms A. During Mr Rondeau's course it was not apparent to me from the teachings about the appliance that it should only be used for Class II malocclusion in 'growing patients'. The teaching was that it could help patients with TMJ symptoms."
- "34 … I sincerely regret the pain and suffering caused to Ms A as a result of the treatment."
- "44 … Certainly in this case I did not have the expertise in or knowledge of M.A.R.A appliances and I should never have recommended the use of one to Ms A. I sincerely regret the problems the use of that appliance has caused to Ms A."

6 We have set out earlier Dr Nguyen's oral evidence in which he apologised for his conduct. The Panel also noted that Dr Nguyen did seek to resolve the patient's complaint at an early stage and there was a payment of some compensation, the details of which need not be recited. In his evidence, Dr Nguyen elaborated upon improvements in his practice which went directly to the matters the subject of this hearing. He was also able to demonstrate

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compliance with previous determinations made by this Board in respect of Dr Nguyen, which we shall allude to shortly.

7 It is important to note that the Panel formed the view that the admissions which Dr Nguyen made were appropriate, well founded upon the evidence and demonstrated an insight into the seriousness of the departure from the standards of expected professional conduct. In the event that an opinion is formed that the determinations did not reflect the seriousness of Dr Nguyen's unprofessional conduct, the Panel reiterates the findings that Dr Nguyen's diagnosis and treatment plan was extremely poor and grossly substandard as well as of a lesser standard than that which either the public or his peers might reasonably expect of Dr Nguyen. The determinations reflect the Panel's balancing of other factors, one of which is not to punish the dental care provider. It is not a function of this Panel to punish the dental care provider for having engaged in unprofessional conduct of a serious nature, but rather to protect the public.

8 One of the matters which the Panel had to consider was the findings of unprofessional conduct of a serious nature made against Dr Nguyen in a previous matter before this Board (see [2004] DPBV 7). Significant in understanding the Panel's view on this matter is the timing. The earlier matter concerned allegations of unprofessional conduct for treatment provided in the period September 2000 to October 2002. Dr Nguyen's Notice of Formal Hearing in that matter was dated 20 February 2004, the hearing was held at the end of April and the decision handed down on 11 November 2004. In the present case, the Services provided to the patient occurred between 9 February and 1 March 2004. The matter did not reach hearing until 27 June 2005.

9 It was plainly apparent from a consideration of both matters that the deficiencies in Dr Nguyen's practice which were apparent in the first matter, were largely responsible for the predicament he found himself in with the patient in this matter. The determinations in the earlier matter included a fine, a caution and reprimand, the undertaking of further education in specific areas and a condition upon undertaking certain complex prosthodontic work.

10 Documentation was tendered indicating that Dr Nguyen had complied with the determinations previously made and had responded well.

11 Considered in this light, the Panel did not consider that its objective of protecting the public would be furthered by either suspending or cancelling the registration of Dr Nguyen or imposing a further fine. It was satisfied that what was appropriate was a condition which would aid Dr Nguyen by reinforcing the lessons which he had learnt from the first hearing, consolidate upon the education and counselling which he undertook, provide a learning opportunity to improve clinical outcomes in the conduct of his practice and for Dr Nguyen to regain confidence in the conduct of his general practice. The imposition of general practice audits was considered by the Panel to be an excellent method by which to achieve these objectives and ultimately protect the public while not denying either it or Dr Nguyen of the benefit in engaging in his chosen profession.

12 It is of course implicit in the above that had Dr Nguyen's conduct taken place later in time and demonstrated that he had not indeed learnt from his mistakes and posed a continuing risk to the public, the outcome may well have been very different. That was not however the position which was presented to the Panel. In making the determinations, the Panel took into account the admissions, the insight into his deficiencies demonstrated by Dr Nguyen and the expressions of regret in not electing to impose harsher determinations which were open to it. The Panel does not consider that Dr Nguyen is at risk of falling into error again but the general practice audits will also serve to monitor Dr Nguyen's professional conduct in an effort to reasonably minimise the risk in all the circumstances.

13 As was stated in the earlier matter and which remains true now, ultimately it is for Dr Nguyen to embrace the opportunity which he has to improve his practices and avoid any possible repeat of the circumstances which have led to this outcome for the patient. If the opportunity is lost, there is no doubt that Dr Nguyen's history before this Panel will be taken into account and it would not be favourable to him.

DATED: 25 July 2005

Victor Harcourt
Chair