

THE DENTAL PRACTICE BOARD OF VICTORIA

Dr Laurence O'Toole [2007] DPBV 2

Panel:

Ms Deborah Foy (Chair)

Dr Gerard Condon

Dr Vlad Hardi

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 12 February 2007

Date of Decision 12 February 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 O'Toole with respect to the allegations the Panel finds Dr O'Toole 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.

The Panel was informed at the outset of the hearing that Dr O'Toole made admissions with respect to paragraphs (a), (b), (c), (d), (e) and (f) of the Notice of Formal Hearing. He also admits the allegation in paragraph (g) but says by way of explanation that he believed that the application of anaesthetic in Mrs AB's circumstances would be ineffective. This was not contested and no finding adverse to Dr O'Toole with respect to that allegation is made.

He also admitted the allegations in paragraph (h), (i) and (j) but explained that he was suffering severe back pain and found himself unable to proceed in his treatment of Mrs AB, due to pain and frustration in his treatment.

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 make no determination.

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 Laurence O'Toole, a registered dental care provider. A Panel was convened and a hearing was held on 12 February 2007.
- [2] The allegations heard by the Panel are contained in an Amended Notice of Formal Hearing, which described the allegations against Dr O'Toole:
- (a) At all relevant times, Dr O'Toole had been registered as a registered dental provider in Victoria under the *Dental Practice Act 1999* ("the Act") or its predecessor, in the *Dentists Act 1972*, having been registered since 1 December 1972.
- [3] **Your Patient**
- (b) On Wednesday 26 April 2006, he provided dental treatment to his patient, Mrs AB.
 - (c) He had treated Mrs AB as his patient since November 2004 and had seen her on at least six occasions prior to April 2006.
 - (d) His patient was aged 65 at the time and, to his knowledge, had earlier suffered rheumatic fever.
- [4] **The Treatment**
- (e) Mrs AB presented herself at his surgery at Cobram in severe pain with an abscessed tooth.
 - (f) He explained to his patient that her tooth was dead and that, to relieve her pain, he would drill a hole in the back of the tooth to allow the pus to drain out of the tooth.
 - (g) He was not able to apply anaesthetic.
 - (h) He commenced the treatment, attempting to make a lingual entry on tooth 21 using a high-speed hand piece.
 - (i) Only minutes after commencing the treatment, and after his patient had flinched in the course of the treatment, he discontinued the treatment, became exasperated, informed his patient that she would have to seek treatment elsewhere, and left the room.
 - (j) He informed his patient at that time that she was not cooperating with him.

- (k) His patient begged him not to leave her and asked him to come back, but he refused, despite the fact that she was distressed and crying and in serious pain.
- (l) Apart from her receptionist offering to telephone her patient's husband, no other assistance or pain relief was offered to her by either him or his staff, resulting in the patient waiting outside the clinic in the gutter for some considerable time for her husband to arrive, and his patient being in continued great pain, distress and anxiety over that time.
- (m) By his conduct, he left his patient in pain and caused his patient severe distress, and feelings of humiliation and abandonment.
- (n) Further, he failed to refer his patient to another dentist, or to an appropriate medical practitioner or hospital, for the management of her condition, when it was necessary and appropriate for him to do so.
- (o) By this conduct, he has engaged in unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.

[5] Such unprofessional conduct is of a serious nature.

[6] At all material times he has been registered as a dental care provider in Victoria under the Act, or its predecessor, the *Dentists Act 1972*, having been so registered since 24 December 1985.

REASONS

[7] On 12 February 2007, the Dental Practice Board of Victoria in a Panel of three members convened to conduct a formal hearing pursuant to the Act into the conduct of the dentist Dr O'Toole.

[8] The Panel was informed at the outset of the hearing that Dr O'Toole made admissions with respect to paragraphs (a), (b), (c), (d), (e) and (f). He also admitted the allegation in paragraph (g) but says by way of explanation that he believed that the application of anaesthetic in Mrs AB's circumstances would be ineffective and this was not contested.

[9] He also admitted the allegations in paragraph (h), (i) and (j) and accepts responsibility for his conduct. He explained that he was suffering severe back pain and found himself unable to proceed in his treatment of Mrs AB, due to pain and frustration in his treatment.

[10] Essentially, the allegations against Dr O'Toole state that when he ran into a difficulty with the treatment, Dr O'Toole effectively abandoned the patient and declined to carry on providing her with dental treatment at a time when she was in considerable pain and distress. By doing so, he caused her further pain and distress and feelings of humiliation and abandonment and another aspect of the case against him is that he failed to refer her to another dentist or a medical practitioner or a hospital for the management of her condition, when it was necessary and appropriate for her to do so.

Evidence of Mrs AB

[11] Mrs AB gave evidence that she had an abscess develop on her tooth and attended the Cobram Hospital where she was prescribed antibiotics and advised to see a dentist on the Wednesday and not before that. She then made an appointment to see Dr O'Toole on that day.

[12] On the day she attended Dr O'Toole, she was in considerable pain which she described as almost unbearable.

[13] Mrs AB told the Panel that "he explained to me when I told him what the problem was that the tooth would have to be drained and I sat in the chair and he put water into my teeth which nearly lifted my head off and then he began to drill on the back of my tooth."

[14] She stated that she flinched when the water went in, but refuted any suggestion that she jumped around.

[15] After Dr O'Toole touched the drill to the back of my tooth and with the water still going in, he switched off the machine and stopped. I thought he had probably forgotten something or needed more equipment and as he walked out the room, he said to me, "I can't deal with you, you'll have to find someone else, you're not cooperating with me, I can't deal with you," and walked out of the room.

[16] Mrs AB gave evidence that she followed Dr O'Toole out of the room and cried out to him for help but he kept going and shut the door in her face.

[17] Mrs AB then told the Panel that she went back into the room, gathered her bag and then went to the reception area. She was crying and upset, in a lot of pain and said to the receptionist, "What do I do now, what will I do" and she said, "I don't know, he said he can't treat you, you'll have to go".

- [18] After an offer from the receptionist to contact Mrs AB's husband who did not have a mobile phone, Mrs AB walked out and went and sat in the gutter to wait for her husband for about three quarters of an hour. She stated that several passers by had attempted to assist her but that she needed to wait for her husband who could not be contacted.
- [19] Subsequently, she received treatment the next day for her abscess at another dental practice.
- [20] She also gave evidence that she had seen Dr O'Toole on six previous occasions when she had been happy with his care.
- [21] Mrs AB was asked if she thought that it might have been possible that Dr O'Toole did not mean to shut a door in her face and that he might not have realised that she had followed him into the tearoom of the surgery. She agreed that this was possible.

Evidence of Dr Roseman

- [22] Dr Roseman gave evidence that he had written an article on "When to refer" for dental care practitioners which appeared in the Dental Practice Board bulletin in April 2004. In Paragraph 4 of the article, Dr Roseman wrote about what should happen if complications occur during dental treatment and the appropriateness of referring such a complication to an appropriate practitioner, medical or dental and advising the patient accordingly.¹

Evidence of Dr O'Toole

- [23] Dr O'Toole provided the Panel with a sworn Affidavit in which he stated that he was aware that Mrs AB was in serious difficulties with a tooth abscess. He found that when he commenced treatment that any action by him caused her considerable pain. In an attempt to enable proper treatment, he found that he needed to position himself in front of her, which caused him significant back pain. He also gave evidence that his back pain was severe and could only be relieved by Panadeine Forte which he could not take while working. He has subsequently required surgery for his back.
- [24] He found that he needed to directly visualise Mrs AB's tooth and so he positioned himself in front of her that caused an increase in back pain. This combined with his failure to relax Mrs

¹ Document B2 in the documents provided to the Panel and numbered BU 48.

AB sufficiently for him to treat her led to such a level of frustration that he knew he needed a minute to collect himself.

- [25] He left the treatment room. He said he recalled Mrs AB asking him to return but denied shutting the door on Mrs AB.
- [26] He gave evidence that he did not see Mrs AB again after he left the treatment room.
- [27] He expressed his deep regret for his treatment of Mrs AB and his failure to meet his obligation to refer those patients whom he had difficulty treating. He acknowledged that he could have referred her for drainage of the abscess under general anaesthetic at Shepparton Hospital.
- [28] He acknowledged that his conduct did not comply with the recommendations made in the article in the Dental Practice Bulletin, an article which he acknowledged that he was familiar with.
- [29] He also expressed his deep regret that Mrs AB had had to wait in such unfortunate circumstances after she left the clinic. He was not aware that Mrs AB was sitting outside the clinic on side of the footpath.

Findings

- [30] The Panel finds that the allegations in the Notice of Formal Hearing are made out with the exception of the allegations in paragraph (g) and (k). The Panel agrees that, in the circumstances, Dr O'Toole could not have administered a local anaesthetic and did not refuse to treat Mrs AB a second time after she called out to him.
- [31] Furthermore, the Panel comments that Dr O'Toole was also not responsible for the fact that Mrs AB could not contact her husband after she left the treatment room.
- [32] The role of the Panel is to protect the public, to maintain the standards of the dental care professions and maintain public confidence in the profession.
- [33] In considering the determination to make, the Panel must weigh up a number of factors.
- [34] The *Dental Practice Act* 1999 does not go beyond the definition of unprofessional conduct and define what is not of a serious nature and what is of a serious nature.

- [35] Counsel Assisting the Panel drew attention to the House of Lords decision of *Gee v General Medical Council*. In that case which deals with a single occasion of conduct, the Court said "Professional misconduct on a single occasion ...(reads)... might not amount to serious professional misconduct," so the word is might "and yet if such failure were persisted in this might make the failures amount to serious professional misconduct."²
- [36] A particular instance of unprofessional conduct may or may not be serious; it depends on the facts of the case.
- [37] The meaning of unprofessional conduct "of a serious nature" has been considered in a number of cases. These include *Parr v Nurses Board of Victoria* (1998) 16 VAR 118 where Kellam J stated that the consideration of the nature of the unprofessional conduct must depend on the facts of the case and further said: "The word serious is defined in the Oxford Shorter Dictionary as being "dealing with or regarding a matter on its grave side, not jesting, trifling or playful; in earnest' and further 'weighty important grave (of quantity or degree) considerable', and 'attended with danger, and giving cause for anxiety'"
- [38] He goes on to say:
- "Clearly such conduct would not be serious if it was trivial or of momentary effect only at the time of commission or omissions by which the conduct was so defined".³
- [39] As Morris J stated in *Kozeniauskas v Dental Practice Board of Victoria* [2005] VCAT 1058 in describing the difference between unprofessional conduct of a serious nature and unprofessional conduct not of a serious nature:
- "Clearly enough, the difference goes to the gravity of the conduct and must depend upon, not only the facts of the case, but also an assessment of the conduct in the context of the conduct of professional practice generally."⁴
- [40] The Panel finds that this single instance of misconduct does constitute unprofessional conduct of a serious nature for the following reasons:
- [41] Dr O'Toole's abandonment of Mrs AB left a 65 year old woman in severe pain with no immediate possibility of resolution. She had been given no advice or referral to a person or agency that could assist her.

² *Gee v General Medical Council* [1987] 2 All ER 193

³ *Parr v Nurses Board of Victoria* [1998] VCAT 16 VAR 118

⁴ *Kozeniauskas v Dental Practice Board* [2005] VCAT 1058

- [42] Dr O'Toole appears not to have taken any steps after collecting himself to provide assistance, advice or referral to another practitioner to Mrs AB when he was well aware that she was in serious distress.
- [43] Had Dr O'Toole undertaken any steps to advise or assist Mrs AB, his conduct could more easily be described as of momentary or of short lived effect.
- [44] The Panel understands that dental care practitioners are human and notes Morris J's comments in *Vissenga v Medical Practitioners Board of Victoria*⁵ where he states:
- “In my opinion, neither the public nor the peers of medical practitioners expect perfection at all times. Human frailty visits every person including those who are medical practitioners. Reasonable people are tolerant of occasional lapses, particularly if those lapses do not form a consistent course of conduct or, if taken separately, are insufficiently serious to warrant intervention by those charged with acting on behalf of the state.”
- [45] Had Dr O'Toole left Mrs AB in the treatment room in order to deal with his frustration, his behaviour may well have fallen into the category of human frailty referred to by Morris J. However, his failure to take any steps subsequently to assist Mrs AB is sufficient to make his unprofessional conduct serious in the Panel's view.
- [46] The Panel also acknowledges that Dr O'Toole has had a long and well-respected career as a committed rural health service provider without blemish. No doubt he has experienced the difficulties from time to time caused by greater distance, as do many other committed rural health practitioners. Dr O'Toole has now ceased to practice.
- [47] The Panel has accordingly decided to make no determination.

Deborah Foy
Chair
3 April 2007

⁵ [2004] VCAT 1044 at para 3