DENTAL PRACTICE BOARD OF VICTORIA

RE: Dr Brett Powell

[2005] DPBV 8

PANEL:

Mr Victor Harcourt (Chair)
Dr Ross Green
Professor Michael Morgan

DATE OF HEARING: 11 July 2005
DATE OF DECISION: 11 July 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 6 May 2005 ("the Notice") to be established:

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

2 On 16 April 2004 a Panel of this Board conducted a Formal Hearing into Dr Powell's conduct.

3 The Formal Hearing was conducted pursuant to a Notice of Formal Hearing under section 45 of the Act dated 16 April 2004 (a copy of which was attached to the Notice) which had been served upon Dr Powell and which identified the allegations to be considered at the Formal Hearing.

4 At the conclusion of the Formal Hearing, the Panel found that Dr Powell had engaged in unprofessional conduct of a serious nature in various respects and also that he had engaged in unprofessional conduct not of a serious nature in two other respects. A copy of the Findings and Determination of the Panel at the conclusion of the Formal Hearing was attached to the Notice (and can be found on the Board's website);

5 After making its Findings, the Panel made a number of Determinations, including the following:

5.1 That Dr Powell should have training in radiation safety by 30 June 2004 in the manner specified in Determination 2.2.

6 Notwithstanding the Determinations, Dr Powell has failed to comply with Determination 2.2, in that he has not completed the stipulated training in radiation safety in the manner specified in Determination 2.2.

7 Dr Powell's failure to comply promptly and appropriately with Determination 2.2 of the Panel at the conclusion of the Formal Hearing constitutes unprofessional conduct as defined in section 3 of the *Dental Practice Act* 1999.

8 Such unprofessional conduct is not of a serious nature.

9 Dr Anthony Roseman is the Investigative Officer of the Board, and the person to whom the Board has delegated the power to conduct preliminary investigations into complaints under section 23 of the *Dental Practice Act* 1999.

10 In the performance of his functions and duties as the Investigative Officer of this Board, Dr Roseman wrote to Dr Powell in regard to a complaint alleging unprofessional conduct on his part in relation to his treatment of Ms A on the following dates:

10.1 4 October 2004; and

10.2 7 December 2004.

11 Dr Powell failed to respond promptly or adequately to these letters.

12 In the performance of his functions and duties as the Investigative Officer of this Board, Dr Roseman wrote to Dr Powell in regard to a complaint alleging unprofessional conduct on his part in relation to his treatment of Ms B on the following dates:

12.1 4 October 2004; and

12.2 7 December 2004.

13 Dr Powell failed to respond promptly or adequately to these letters.

14 Dr Powell's failure to respond promptly or adequately to this correspondence constitutes unprofessional conduct as defined in section 3 of the *Dental Practice Act* 1999.

15 Such unprofessional conduct is not of a serious nature.

16 On 12 August 2003 and pursuant to section 69(1)(e) of the *Dental Practice Act* 1999, the Board promulgated (and later publicised) a Code of Practice Number C003 entitled Dental Records ("the Code").

17 Over the period from August 2003 to March 2004, Dr Powell provided dental treatment to his patient Ms A.

18 Over the period from November 2003 to July 2004 Dr Powell provided dental treatment to his patient Ms B.

19 In breach of provisions of the Code, Dr Powell failed to maintain adequate and appropriate dental records of his treatment of each of these patients.

20 Particulars of the respects in which Dr Powell's dental records were not adequate or appropriate and did not comply with the Code are as follows:

20.1 Ms B - there is no record of the following: presenting complaint; relevant history; clinical findings; diagnosis; treatment plan; information given to obtain consent; medical history; examination performed; clinical findings, observations and some procedures; communication with a dental laboratory; a prescribed antibiotic on 9 June 2004; form, strength or quantity of antibiotics prescribed 19 November 2003 and 9 June 2004; appointment alleged by patient on 26 November 2003; and phone calls to and from patient between 26 November 2003 and 9 June 2004.

20.2 Ms A - there is no record of the following after 12 August 2003: presenting complaint; relevant history; clinical findings; diagnosis; the information given to obtain consent; medical history or update; examination performed; clinical findings, observations and some procedures; and form, strength and quantity of local anaesthetic (S4) administered 18 March 2004.

21 Dr Powell's failure to maintain adequate and appropriate dental records of his treatment of these patients constitutes unprofessional conduct as defined in section 3 of the Act.

22 Such unprofessional conduct was not of a serious nature.

23 Over the period from 19 November 2003 to 22 July 2004 Dr Powell provided dental treatment to Ms B, comprising crown preparations, impressions and temporary crowns placed on teeth 23, 33 and 34.

24 In respect of the dental work provided to Ms B:

24.1 teeth 23, 33 and 34 were overlaid with composite resin;

24.2 teeth 33 and 34 had been splinted together;

24.3 these temporary restorations were of a poor standard and over-contoured; and

24.4 there was also associated gingival inflammation

- but the conduct of Dr Powell in providing such dental work did not constitute unprofessional conduct of either a serious nature or not of a serious nature.

25 Dr Powell failed to respond promptly and appropriately to his patient's ongoing needs for his treatment plan to be completed, and in particular:

25.1 Dr Powell failed to provide and fit the proposed final crowns for teeth 23, 33 and 34 within a reasonable time; and

25.2 Dr Powell delayed the treatment unacceptably and inappropriately.

26 Dr Powell's failure to complete the treatment plan constitutes unprofessional conduct as defined in section 3 of the *Dental Practice Act* 1999.

27 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 Powell's registration as a dental care provider:

1.1 Dr Powell submit his practice to an audit every six months to assess ongoing compliance with his professional obligations in the conduct of his dental care practice. In particular, the audit is to focus upon whether Dr Powell is responding promptly and appropriately to his patients' ongoing needs for the treatment plan to be completed within a reasonable time and, if not, the reasons for this. Express consideration shall be given to whether the reasons lie in Dr Powell's failure to respond to his professional obligations or in prevaricating in the face of difficulties, such as patient management, technical failings or inadequacies in the diagnosis or treatment plan.

1.2 The audit is to be undertaken at Dr Powell's expense by a person first approved of by an authorised officer of the Board. The nature of the audit must also be first approved by an authorised officer of the Board. The audits are to be conducted until 30 September 2007 and the first audit must be completed by 30 September 2005.

1.3 The results of the audit 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 Powell. Dr Powell must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit.

2 Dr Powell must undertake further education in record-keeping by 30 September 2005. The further education should be conducted by the Health Services Commissioner or a member of her staff, or a person with appropriate expertise from the Department of Human Services or otherwise as approved by an authorised officer of the Board. The further education is to be undertaken at Dr Powell's expense and the content and nature of the education must be first approved by an authorised officer of the Board. The provider of the education, if it is not the Health Services Commissioner or a member of her staff, or a person with appropriate expertise from the Department of Human Services, must be first approved by an authorised officer of the Board.

3 Dr Powell must undergo counselling by 30 September 2005 in the areas of complying with Determinations, responding to Board correspondence and patient complaints, and the professional obligations of a dental care provider generally. The counselling should be conducted by a senior member of the dental care profession. The counselling is to be undertaken at the expense of Dr Powell, and the nature, content and provider of the counselling must be first approved of by an authorised officer of the Board.

4 If Dr Powell fails to comply with the condition on his registration, his registration as a dental care provider is suspended from the date of non-compliance until the date of compliance.

5 The Panel reprimands Dr Powell for his unprofessional conduct.

6 The Panel also cautions Dr Powell against a repetition of his unprofessional conduct, including his failure to properly adhere to the requirements of the Determinations made by the Board. In particular, Dr Powell is cautioned that he must complete the radiation safety training which was approved of and implemented, but not wholly completed. The Panel was prepared to give to Dr Powell the benefit of the doubt that his failure to respond to his professional obligations was caused by anxiety rather than a contempt for the importance of maintaining professional standards. The Panel considered that Dr Powell should be given the opportunity to face up to his professional obligations and improve his practices.

<u>REASONS</u>

1 On 11 July 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 Brett Powell. Dr Powell was at all material times a registered dental care provider.

2 At the commencement of the hearing, Dr Powell made certain admissions which the Panel found to be appropriate and made the following findings: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 23, 24 (in part), 25, 26 and 27. Dr Powell was frank and open in the admissions which he made, put in issue appropriate matters and did not seek to avoid taking responsibility for the mistakes which he admitted to. Dr Powell relied upon an affidavit which he had sworn and which was tendered during the course of the hearing. Dr Powell provided a reasonable explanation as to why Determination 2.2 had not been completed in a timely manner. He expressed a willingness to meet with the person who had provided the training to complete the feedback session on the work submitted by Dr Powell.

3 In his affidavit, Dr Powell also made the following relevant comments:

- "33. I acknowledge that my treatment of Ms B was deficient in the months that followed in that I permitted an unacceptable and inappropriate delay to occur. I should have taken steps to ensure that treatment plan was finalised within a reasonable time. I apologise for these matters. I am willing to undergo whatever form of remedial training or counselling which the Board considers appropriate."

- "34. I acknowledge that I failed to deal promptly or adequately with the letters sent to me by the Board dated 4 October 2004 and 7 December 2004. I can proffer no satisfactory explanation for my failure, for which I apologise."

- "35. I am resolved to paying close and prompt attention to any future correspondence I receive from the Board and to the extent that this reflects on the administration of my practice, I have already introduced measures to improve communication, filing and recording of information within my office."

4 Dr Powell's affidavit also contained evidence of other steps which Dr Powell has taken to improve. The Panel noted these steps taken by Dr Powell with approval. The onus is now upon Dr Powell to ensure that he adheres to the steps outlined in his sworn affidavit

5 If we turn now to the matters which were in issue in the light of the admissions, the Panel had three areas before it in which the question was whether admitted unprofessional conduct was not of a serious nature or was of a serious nature. This related to Dr Powell's failure to comply with the Board's Determination, his failure to respond to Board correspondence and the defective record-keeping. The Panel was satisfied, on the evidence before it, that in each case Dr Powell's unprofessional conduct was not of a serious nature.

6 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. 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 and *Domburg v Nurses Board of Victoria* [2000] VSC 369. Most recently, Morris J in *Kozeniauskas v Dental Practice Board of Victoria* [2005] VCAT 1058 stated the following:

> "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."

7 The Panel formed the view that the deficiencies could not be considered of a serious nature for the following reasons:

- There was a reasonable explanation for Dr Powell's delay in complying with Determination 2.2 which had been satisfied in all respects but for the conduct of a formal feedback session by the time of the hearing. Dr Powell should have been more assiduous in meeting the deadlines imposed however;

- Dr Powell's failure to respond to Board correspondence resulted from his anxiety which seemed to typify his responses to difficulties encountered during the course of his practice, rather than a contemptuous regard for his professional obligations;

- While Dr Powell's records were defective in a number of respects for the two patients concerned, Dr Powell identified a number of improvements to his practice to address the deficiencies in the future. Further, placing Dr Powell's failure in the context of the conduct of professional practice generally, the Panel was not prepared to form the view that it was unprofessional conduct of a serious nature.

8 The final area upon which the Panel was required to consider on the allegations, was the extent to which the dental work which was provided to Ms B was:

8.1 extremely poor;

8.2 grossly substandard;

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

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

9 The allegations further particularised the alleged deficiencies in the dental work as follows:

9.1 The underlying tooth preparations on teeth 23, 33 and 34 were rudimentary and required further tooth reduction when the work was completed by another practitioner;

9.2 Teeth 23, 33 and 34 were overlaid with composite resin;

9.3 They had not been cemented as temporary crowns, but fabricated directly in the mouth;

9.4 Teeth 33 and 34 had been splinted together;

9.5 These temporary restorations were of a poor standard - over-contoured and unaesthetic; and

9.6 There was also associated gingival inflammation.

10 In support of these allegations, counsel assisting the Panel called evidence from Dr C who completed the treatment commenced by Dr Powell upon Ms B.

11 In seeking to evaluate the evidence against Dr Powell and in support of the above allegations, the Panel was mindful of the *Briginshaw Test*, as it is now known and the cases which have explained its application. There is no need here to elaborate upon this line of authority other than to say that the seriousness of the allegations against Dr Powell required the Panel to assess the strength of the evidence which was adduced to support the allegation, in the context of the seriousness of the allegations which were being made.

12 Ultimately, the Panel could only be satisfied about the following allegations:

- Teeth 23, 33 and 34 were overlaid with composite resin;
- Teeth 33 and 34 had been splinted together;
- The temporary restorations were of a poor standard - over-contoured; and
- There was also associated gingival inflammation.

13 While the Panel formed the view that the quality of the dental work performed by Dr Powell was less than optimal, it was not of a sufficiently poor standard to form the basis of a finding of unprofessional conduct as that term is defined in the *Dental Practice Act* 1999. It is implicit in this statement that not all deviations from expected standards represent unprofessional conduct and this has been supported by comments in many cases dealing with this topic.

14 Having made the above findings, the Panel then had to consider the Determinations to be made. In this regard, in the areas in which the Panel had found Dr Powell had engaged in unprofessional conduct not of a serious nature, being failure to comply with the Board's determination, failure to respond to Board correspondence and defective record-keeping, the Panel had open to it one or more of the following:

- Counselling

- Further education
- Caution
- Reprimand.

15 In respect of Dr Powell's unprofessional conduct of a serious nature, the Panel could also impose the following Determinations:

- A condition, limitation or restriction on registration;
- A fine;
- Suspension of registration;
- Cancellation of registration.

16 Counsel assisting the Panel made the following submission with which the Panel concurs:

> "We see a symptomatic situation here which underlies all four of the aspects of this case and previous - and the findings in the previous case of a failure by Dr Powell to recognise and respond appropriately to professional difficulties which face him in the day to day running of a practice, whether it be fulfilling his obligation under a Determination of the Board, answering correspondence from the Board, dealing with complaints from his patients, responding to the ADA, dealing with whatever difficulty it was that his treatment of Ms B presented, he seems to prevaricate, he seems to have a difficulty in confronting and dealing with issues at an appropriate time with the result that those issues escalate and become more and more difficult to deal with over time."[1]

17 On behalf of Dr Powell, counsel highlighted the improvements to Dr Powell's practice which he has undertaken in response to the problems identified in the Notice. Dr Powell in his affidavit indicated a ready willingness to undertake appropriate training, education and counselling which was repeated in his counsel's submissions.[2]

18 The Panel's function in making the Determinations is one of protecting the public and not of punishing the dental care provider. In seeking to formulate Determinations which protected the public, the Panel had to form a view about the underlying causes of the problems manifest in the Notice and upon which Findings have now been made against Dr Powell. The Panel was prepared to give Dr Powell the benefit of the doubt in this regard and accept the proposition that his anxiety caused him to act in a less than satisfactory manner in the face of professional difficulties. The Panel did not form the view that Dr Powell was acting in contumelious disregard of either his responsibilities to the Board or to his patients. In the previous decision concerning Dr Powell, the following comments were made:

> "The Panel considered that Dr Powell did not fully understand his responsibilities as a practice owner and employer, or his obligations as a professional person with regard to patient safety and infection control. The Panel was strongly of the view that Dr Powell needed to honour his professional obligations immediately and he certainly needed to do so before a member of the public was injured by reason of his failures …"

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[1] T127-128.
[2] T133.

19 These comments remain pertinent although it can be observed that the matters which are before the Panel on this occasion are not on a par or as extensive as the matters the subject of the Panel's decision on 27 April 2004.

20 The Panel was of the view that Dr Powell would benefit from education and counselling to assist him in complying with his obligations. The audit condition on Dr Powell's registration serves a dual purpose. One being to protect the public by ensuring independent monitoring of Dr Powell's practice, the other being to give Dr Powell the opportunity to improve quality and safety in his patients' outcomes.

21 The Panel has provided to Dr Powell the opportunity to improve his practices and to avoid adverse outcomes for patients in the identified areas of deficiency. This remains true not only in this matter but in the previous matter concerning Dr Powell. If the opportunity is lost, and Dr Powell again presents before this Board on allegations of unprofessional conduct, Dr Powell's history will be taken into account in any Determination which may be made, and it is unlikely to be favourable to him.

DATED: 8 August 2005

Victor Harcourt
Chair