

DENTAL PRACTICE BOARD OF VICTORIA

RE: Dr Nathan Rosen

[2006] DPBV 3

PANEL:

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

DATE OF HEARING: 16 May 2006

DATE OF DECISION: 16 May 2006

FINDINGS

The Panel, having considered the evidence and submissions placed before it, finds the following allegations in the Notice of Formal Hearing under section 45 of the *Dental Practice Act* 1999 ("the Act") dated 24 April 2006 ("the Notice") to be established:

- 1 At all material times Dr Nathan Rosen has been registered as a dental care provider in Victoria under the Act.
- 2 On 1 March 2005 the Dental Practice Board of Victoria promulgated Code of Practice No.C006, about the practice of dentistry entitled, "Infection Control", under section 69(1)(e) of the Act.
- 3 At that time, and thereafter, this Code of Practice was widely publicised within the dental profession in Victoria initially during or about March 2005 by being posted to all registered dental care providers in Victoria, and thereafter by being posted on the Board's website. Attached to the notice of hearing is a copy of the infection control Code of Practice No.C006. It is not necessary for that code to be appended to the findings.
- 4 The Code of Practice requires in paragraph 8 that every registered dental care provider must:
 - 4.1 Ensure the premises in which he or she practises are kept in a clean and hygienic state to prevent the spread of infectious disease;
 - 4.2 Ensure that in attending a patient he or she takes such steps as are practicable to prevent or contain the spread of infectious disease; and
 - 4.3 Act in accordance with the requirements set out in the three documents referred to at paragraph 7 of the Code of Practice, namely, the Practice Manual, AS/NZS4815:2001 and the Commonwealth Government publication "Infection Control Guidelines for Prevention of Transmission of Infectious Diseases in the healthcare setting", published January 2004.
- 5 Dr Rosen, being a dentist bound by the Act and maintaining premises in which he practises at 769 Doncaster Road, Doncaster, is in breach of the Code of Practice.
- 6 Dr Rosen has breached his obligations under paragraph 8 of the Infection Control Code of Practice No.C006 in various respects and particulars of such breaches appear in a document attached to the notice of formal hearing and headed, "Practice Inspection, Dr Nathan Rosen, 769 Doncaster Road, Doncaster".
- 7 The notes in the Practice Inspection document identify breaches by Dr Rosen of the provisions referred to in those notes of the *Health Records Act* (2001), the *Health Act* (1958),

the *Occupational Health and Safety Act* (2004), the *Drugs Poisons and Controlled Substances Act* (1981), the *Drugs Poisons & Controlled Substances Regulations* (1995), the Infection Control guidelines publication referred to previously in these findings and Australian Standard 4815:2001.

- 8 Accordingly and by his conduct Dr Rosen has engaged in unprofessional conduct as defined in section 3 of the *Dental Practice Act* (1999).
- 9 Such unprofessional conduct is of a serious nature.

DETERMINATION

Having considered the matter and having given due weight to the submissions placed before the Panel, the Panel considers it appropriate under section 47(2) of the Act to impose the following determinations:

- 1 Dr Rosen is fined the sum of \$1,500.00 to be paid by 30 June 2006.
- 2 A condition is to be imposed upon Dr Rosen's registration that he submit his practice to an audit every six months to assess Dr Rosen's ongoing compliance with his professional obligations concerning infection control in the conduct of his dental care practice. The audit is to be undertaken at the expense of Dr Rosen by a person first approved of by an authorised officer of the Board and the nature of the audit must also be first approved by an authorised officer of the Board. These audits are to be conducted for a period of two years from the date of the first audit, which is to be conducted by 31 July 2006. The audits are to be conducted on a six monthly basis thereafter. The results of the audits are to be provided directly to an authorised officer of the Board within two weeks of the audit and a copy is to be provided to Dr Rosen. Dr Rosen must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit.
- 3 Dr Rosen is reprimanded for his conduct, found to be unprofessional conduct of a serious nature.
- 4 Dr Rosen is cautioned in respect of that conduct in the future conduct of his practice.

REASONS

- 5 On 16 May 2006, the Dental Practice Board of Victoria ("the Board") in a panel of three members ("the Panel") convened to conduct a formal hearing pursuant to the *Dental Practice Act* 1999 (Vic) ("the Act") into the conduct of the dental care provider, Dr Nathan Rosen. Dr Rosen admitted all of the allegations in the Notice including the deficiencies described in the Practice Inspection report which is attached to the Notice of Formal Hearing, save in four respects identified in paragraphs 10 to 14 of the affidavit of Dr Rosen which was sworn 16 May 2006 and tendered to this Panel on the day of hearing.
- 6 The Practice Inspection report identifies the following. "That Dr Rosen was unable to produce a practice manual. A copy of the Infection Control Guidelines for Prevention of Transmission of Infectious Disease in the Health Care setting published by the Commonwealth Government Department of Health and Aging 2004 or Australian Standard AS/NZS4815:2001. There was no evidence of a Practice Privacy policy. There was no evidence of registration of the X-ray machine or a licence to operate it. Dr Rosen could not produce safety data sheets for any materials used in the practice including Aidal Plus".
- 7 Dr Roseman in the Practice Inspection report describes the practice being located in a converted house consisting of a waiting area and two equipped surgeries. Dr Rosen informed Dr Roseman that one of the surgeries was not used on a regular basis and that cleaning and sterilization of the instruments was carried out in a separate area, part of which

also serves as laboratory. Dr Roseman had described the premises as generally unclean and unhygienic.

- 8 As with some earlier comments made by Dr Roseman, Dr Rosen takes issue with that statement. Dr Roseman then goes on to describe the practice as follows, "In the surgery there is an instrument processing area, there's no evidence of appropriate zoning and no protocol for the management of contaminated spills. Barrier techniques were inadequate. There was no protocol for the appropriate management of water lines. Latex gloves were available there were no non latex gloves and there was no sterile gloves present. The hand washing sinks in the surgery were equipped with wrist taps. There was not detergent available for hand washing and hands are dried with cloth towels. Dr Rosen advised that gowns were changed every two or three days. And masks were not routinely changed between patients. Instruments were not routinely bagged prior to sterilisation. Instruments were stored un-bagged in drawers and cupboards which Dr Rosen advised were cleaned on an irregular basis. They were not resterilised immediately prior to use. Local anaesthetic was not stored in a locked cupboard. Sharps were not disposed of by the operator 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".
- 9 Dr Roseman goes on to observe that, "The area used for the processing of instruments was untidy and not clean. Work flow patterns were incorrect. There was insufficient personal protection for staff involved in the treatment of used items, i.e. no waterproof apron, mask or eye protection. There was no evidence that instruments were processed in accordance with Australian Standard AS/NZS4815:2001. Ultrasonic cleaners in the instrument processing area not properly maintained. Dr Rosen had no evidence of calibration validation of the autoclave, and there were no records of the testing and maintenance of the autoclave".
- 10 He also observed that, "The interview with Dr Rosen indicated in his opinion that Dr Rosen had little knowledge or understanding of the principles in infection control and the protocols required to maintain a safe practice". The Practice Inspection report then goes on to note that, "At the conclusion of the inspection Dr Rosen voluntarily agreed to cease practice immediately until such time as certain minimum standards for infection control had been attained". Those standards were, "(1) Autoclave to be calibrated and validated and a printout of each cycle available. (2) Processing of instruments according to Australian Standard AS/NZS4815:2001. (3) Critical instruments to be bagged. (4) Instruments to be stored in accordance with Australian Standard AS/NZS4815:2001. (5) Adequate hand washing and gloving protocols. (6) Proper barrier techniques to be implemented. (7) Premises to be made clean and hygienic".
- 11 As mentioned earlier Dr Rosen in addition to making the admissions which the Panel appreciates, tendered an affidavit in which he set out a number of matters which went to the question of determinations primarily, although there are certain matters identified in Paragraphs 10 to 14 which go to some of the observations of Dr Roseman.
- 12 For the purposes of the findings we will refer to those matters although it's not determinative of the findings which we've made to resolve, to the extent that there is a factual difference in the observations of Dr Roseman and Dr Rosen. By way of introduction Dr Rosen at Paragraph 9 of his affidavit acknowledges that Dr Roseman's observation regarding infection control practices at his clinic, which is set out in the Practice Inspection report are on the whole accurate. He then identifies the following observations which he disagrees with:
- 13 "Paragraph 10. Dr Roseman says in his report that there was no evidence of registration of the X-ray machine or a licence to operate it in breach of the Health Act. Although it is true that I did not have the registration document for the X-ray machine, nor the licence available to show Dr Roseman at the time of his inspection, the current registration and licence

documents were in fact in my possession and filed at my home". Dr Rosen then attaches as an exhibit a true copy of the registration and licence.

- 14 "Paragraph 11. Dr Roseman has observed that I could not produce safety data sheets for any materials used in my practice including Aidal PLUS. Although I acknowledge that safety data sheets for all materials were not available at the time of inspection by Dr Roseman, I did in fact possess relevant safety data sheets for most filling materials. Further I believe that a safety data sheet was not provided to me at the time I purchased Aidal PLUS from Halas, dental material suppliers. Aidal PLUS is a disinfectant material".
- 15 "Paragraph 12. I note Dr Roseman's observation that the premises were generally unclean and unhygienic. The premises to which Dr Roseman refers comprised a converted house. The converted house consisted of a waiting room leading from the entry, which then opened up to a hallway, which lead to two surgical rooms. The hallway then continued on to open up into a first room, which was used for sterilisation and a further room at the rear which was used as a laboratory. There are additional rooms located parallel to the surgeries which I kept vacant and for use as storage as required".
- 16 "Paragraph 13. I do not believe Dr Roseman's description of the clinic as unclean and unhygienic is an accurate one. The waiting room and surgeries were clean. I accept that particularly in relation to the sterilisation room and laboratory that the rooms were not as well organised and tidy as they should have been, and that storage of equipment in the rooms gave the impression that the rooms were unkempt and untidy. However. I accept that the fact that the converted house was constructed in 1950's and had not been renovated since that time may have given the impression that the rooms were in need of repair. For example the floor surface in the laboratory and the sterilisation room was covered by torn linoleum and paint was peeling from sections of the walls. Notwithstanding the appearance of the property itself the floors and benches and all rooms were regularly cleaned by my staff".
- 17 And then at Paragraph 14 Dr Rosen states, "I do not agree with Dr Roseman's assessment of zoning in the surgeries and instrument processing areas. I believe that appropriate covers were used in dirty areas and these clearly distinguish from clean areas in my practice". For the purposes of assisting in this matter to the extent that the Panel has considered the documents including the photographs, insofar as Dr Roseman has observed that the premises were generally unclean and unhygienic the Panel does not consider that to be as significant an issue as the observations concerning the sterilisation area. The term "unclean and unhygienic" may not have been a description which the Panel would have used based on the photographs.
- 18 We believe that the main issue relates to the sterilisation area, which based on the photographs are clearly substandard and could be described as unclean and unhygienic. We will turn now to the determinations.
- 19 There is no excuse for Dr Rosen putting the public at risk in his surgery in relation to significant and widespread deficiencies in infection control. While it was to his credit that when faced with Dr Roseman's observation Dr Rosen closed the practice and undertook comprehensive steps to rectify the problems, his own admitted ambivalence about the direction of the practice which compromised patient safety was and is not acceptable.
- 20 By Dr Rosen's own admission he read the Code of Practice after its release in March 2005 but did nothing. We note indeed that many of the deficiencies related to basic requirements of acceptable infection control that have been in place for many years. This failure was unacceptable, inexplicable and symptomatic of Dr Rosen's admitted own lack of direction. We are informed and accept that Dr Rosen has now reformed his practice, and now has a renewed commitment to his practice and protecting his patients. Placed into evidence were two reports of Dr Amerena. The first report provided by Dr Amerena dated 27 September 2005 was within a short period of time of the first practice inspection.

- 21 Dr Amerena concluded by stating that in the two and a half working days since he first visited great progress had been made. Dr Amerena identified steps which were to be taken after that point. Dr Rosen's affidavit certainly identified the comprehensive steps which had been undertaken to address the deficiencies which had been identified. In a further report from Dr Amerena dated 11 May 2006 he stated he was pleased to report that the infection control procedures in place are excellent, as are the facilities and equipment present.
- 22 Notwithstanding that Dr Amerena identified that there were still some deficiencies. Some of which or at least one of which related to deficiencies identified in the visit by Dr Roseman. There are other matters which Dr Amerena identified which needed to be addressed, and we are satisfied that the steps are in place to address those deficiencies, but that the practice audits are necessary to ensure a continuing adherence to acceptable standards of infection control.
- 23 The Panel was concerned that there was a lack of contrition expressed by Dr Rosen in relation to the danger which was posed to his patients. While we accept that Dr Rosen had a lack of direction, which led to a compromise in patient safety, we were not satisfied that in fact there was sufficient insight into the degree of risk which had been posed to the public while he practised in an unsafe manner. And that whilst Dr Rosen's comments focused upon his own renewed commitment and the fact that he preferred practising in this way rather than the old, our function goes very directly towards protecting the public.
- 24 In the Panel's opinion this is a message that Dr Rosen needs to take on board so that in the future if there is any lack of commitment on his part, in relation to what direction he takes either in practice or professional life, it does not put at risk the public. It's against that eventuality that we caution Dr Rosen against. The appropriate steps to take are not to become lackadaisical in regard to patient safety, but to consult with others in relation to dealing with a lack of commitment.
- 25 It is for those reasons too that the Panel considered that in the exercise of its proper functions and in terms of specific and general deterrence, there be a fine in the amount of \$1500. The quantum speaks for itself in terms of its relative comparison to other matters which have come before the Board. It was appropriate that Dr Rosen admitted his conduct was unprofessional conduct of a serious nature. The determinations took into account the admissions. The Panel considers Dr Rosen's involvement in these proceedings, the determinations that have been made and his own evidence will ensure that patient safety in his practice is not compromised again in the future.

DATED: 13 June 2006

**Victor Harcourt
Chair**