

GENERAL DENTAL COUNCIL

AND

MEW, Michael Gordon

[Registration number: 69138]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

An inquiry conducted by the Professional Conduct Committee opened on 14 November 2022 and adjourned part-heard on 25 November 2022. The hearing then resumed on the following dates:

3 -6 April 2023; 19 – 23 June 2023; 3 – 21 July 2023; 6 -8 September 2023; 9 – 13 October 2023; 13-17 November 2023; 7-9 February 2024; 6 March 2024; 15 -19 April 2024; 15 – 19 July 2024 and 7 – 11 October 2024.

The hearing will resume at 09:30 am on 04 November 2024. Please note that this hearing will take place in person at the Wimpole Street address listed below.

**The General Dental Council
37 Wimpole Street
London
W1G 8DQ**

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at <https://www.dentalhearings.org/hearings-and-decisions/decisions> after this hearing has finished.

Committee Members:	Andy Skelton	(Lay) (Chair)
	Louise Fletcher	(DCP)
	Carson Black	(Dentist)

Legal Adviser: Paul Kilcoyne

CHARGE

MEW, Michael Gordon, a dentist, BDS Lond 1993, is summoned to appear before the Professional Conduct Committee on 14 November 2022 for an inquiry into the following charge:

“That, being a registered dentist:

1. Between September 2013 and May 2019, you provided advice and treatment to:
 - (a) Patient A, identified in Schedule A¹; and
 - (b) Patient B, identified in Schedule A.

Patient A

2. In September 2016, when Patient A was 6 years old, you recommended she underwent treatment you referred to as ‘Orthotropic’ treatment involving:
 - (a) upper and lower arch expansion appliances;
 - (b) the wearing of neck gear.
3. You informed Patient A’s parents that the principal aims of the treatment you proposed were:
 - (a) to expand Patient A’s upper and lower arches and thereby “make way for the tongue, far more than would be required for the teeth”;
 - (b) to “gain a substantial increase in nasal capacity”;
 - (c) to “improve the midface (the area under the eyes and either side of the nose)”;
 - (d) to “change the swallowing pattern”;
 - (e) to “correct the cause of the problem and guide facial growth and development through gaining structural changes of facial and dental form” and through “correcting the oral environment in this way, more space for the teeth and tongue is created, so that all the 32 teeth (including the wisdom teeth) align naturally without the need for fixed braces”;
 - (f) based on, “the Tropic Premise which states that anyone who exhibits a number of features will have permanently well aligned teeth and good facial form”, the features to be exhibited including standing up straight, establishing a lip seal with nasal breathing, maintaining a “Butterfly bite”, resting with the tongue on the roof of the mouth and swallowing with the tongue on the roof of the mouth.
4. Patient A had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development.
5. Your recommendations for treatment and comments as set out at paragraph 2 and/or 3 were inappropriate and/or misleading in that:
 - (a) treatment was not clinically indicated for Patient A;
 - (b) you had no adequate objective evidence to suggest the treatment proposed

¹ Schedule A is a private document which cannot be disclosed.

for Patient A would achieve the aims stated.

6. You inappropriately informed Patient A's parents:
 - (a) "Most orthodontists have been told that we are not evidence based and are "bad" but few really have any idea of what we do";
 - (b) "for younger children it is also important to push many orthodontists into giving their opinion as to what may happen in the future, as it is too easy to sit on the fence and placate parents for years until it is too late to avoid extractions or surgery."
7. On 20 September 2016 Patient A was fitted with upper and lower expansion appliances.
8. On 6 October 2016 Patient A was fitted with neck gear.
9. On or about 2 November 2016 you recommended Patient A underwent a lingual tongue-tie release for a tongue tie which you stated:
 - (a) was restricting her ability to rest with her tongue on the roof of her mouth comfortably at rest;
 - (b) was creating an imbalance in the strength of her jaw and tongue muscles;
 - (c) was responsible for night-time teeth grinding and clicking;
 - (d) was negatively affecting her oral posture and which, if left untreated, would negatively impact her facial growth and dental malocclusion;
 - (e) if treated, would complement her 'Orthotropic' therapy with the result that she would not need orthodontic or other intervention at some point in the future.
10. Your recommendation that Patient A underwent a lingual tongue-tie release and your comments as set out at paragraph 9 were inappropriate and/or misleading in that:
 - (a) a lingual tongue-tie release was not clinically indicated for Patient A;
 - (b) you had no adequate objective evidence to suggest a lingual tongue-tie was causing the issues stated or potential issues;
 - (c) you had no adequate objective evidence that a lingual tongue-tie release would achieve the outcomes indicated or implied.
11. On 8 May 2017 Patient A was seen by a Consultant Oral and Maxillofacial Consultant and found:
 - (a) not to require a lingual tongue tie-release;
 - (b) to have developed a large anterior open bite;
 - (c) to have a traumatic ulcer on the lingual frenum.
12. A photograph taken in September 2017 shows Patient A had recession of the labial gingiva of the permanent lower incisors.
13. A photograph taken in April 2019 shows Patient A had:
 - (a) recession of the labial gingiva of the permanent lower incisors;
 - (b) an unresolved anterior open bite;

- (c) an unaligned UL2.
- 14. In respect of Patient A:
 - (a) you failed to carry out appropriate and/or adequate monitoring of her treatment;
 - (b) you failed to carry out any cephalometric analysis or similar.
- 15. You ought to have known that that the treatment provided to Patient A as set out at paragraph 7 and/or 8:
 - (a) was not clinically indicated for Patient A;
 - (b) was not in Patient A's best interests;
 - (c) was liable to cause harm.

Patient B

- 16. In November 2013, when Patient B was 2 years old:
 - (a) you took an upper impression with the intention of providing an expansion appliance;
 - (b) you informed Patient B's parents that the aim of the proposed expansion appliance would be to improve tongue space and upper nasal airway.
- 17. The treatment proposed and comments as set out at paragraph 16 were inappropriate and/or misleading in that:
 - (a) treatment was not clinically indicated for Patient B;
 - (b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.
- 18. In February 2018, when Patient B was 6 years, you reviewed him and informed Patient B's parents:
 - (a) that, "both upper and lower jaws have dropped down as is consistent with the concept of Craniofacial Dystrophy";
 - (b) the aim of treatment you proposed for Patient B would be, "to improve the craniofacial development so that he no longer had any sleep issues and create an environment in which the teeth align themselves";
 - (c) "As the upper and lower jaws have dropped down and back, the face has lengthened affecting the airway leading to a forward head posture and a modified resting tongue position. The latter dictating a pattern of malocclusion that we see";
 - (d) the aim of treatment you proposed for Patient B would be, "not to align teeth but create an environment in which teeth will align themselves as they do in 5,400 species of mammals and our ancestors since the dawn of time."
- 19. You recommended Patient B underwent treatment you referred to as 'Orthotropic' treatment involving:
 - (a) the widening of both arches, with greater widening of the maxilla;
 - (b) the wearing of head gear at night;
 - (c) the potential provision of a 'Myobrace' or 'training appliance'.

20. Patient B had a Class 1 occlusion on a Class 1 skeletal base and normal craniofacial development.
21. Your recommendations for treatment and comments as set out at paragraph 18 and/or 19 were inappropriate and/or misleading in that:
 - (a) treatment was not clinically indicated for Patient B;
 - (b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.
22. On 16 August 2018 Patient B was fitted with upper and lower arch expansion appliances.
23. On 23 August 2018, following questions and concerns raised by Patient B's parents, you informed them:
 - (a) that the treatment you proposed "was designed to create more space for the tongue and then train an individual to change. In this way, it becomes easier for patients to correct themselves. Malocclusions improve and there is a positive impact on the airway with improved sleep, fewer nasal obstructions and better oral posture";
 - (b) "the changes they achieve are stable and as long as patients continue to be aware of their oral posture, these changes are permanent";
 - (c) that in Patient B's case, "there is a lack of space for his tongue and this is the reason his facial form has down swung";
 - (d) "It is necessary in his case to gain this additional space by widening his arches as well as lengthening".
24. Your recommendations for treatment and comments as set out at paragraph 23 were inappropriate and/or misleading in that:
 - (a) treatment was not clinically indicated for Patient B;
 - (b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.
25. On 30 August 2018 Patient B was provided with head gear.
26. In respect of Patient B, you failed:
 - (a) to carry out any cephalometric analysis or similar;
 - (b) to treat or ensure decay was treated at ULD, ULE, LLD, URE, LRE and/or LRD prior to commencing treatment;
 - (c) to obtain study models;
 - (d) to communicate with Patient B's paediatrician;
 - (e) to carry out appropriate and/or adequate monitoring.
27. On 10 December 2018 Patient B was seen by another practitioner and found to have recession of the labial gingiva of a permanent lower incisor.
28. You ought to have known that the treatment provided to Patient B as set out at paragraph 22 and/or 25:

- (a) was not clinically indicated;
- (b) was not in Patient A's best interests;
- (c) was liable to cause harm.

“YouTube”

29. In a video posted on YouTube in about September 2017 titled “Orthodontics Beyond Teeth” you stated:
- (a) words to the effect, that if you create enough tongue space, and children use that tongue space, that can influence facial growth and the craniofacial structure and, “expansion of the brain, expansion of the dental arches as well”;
 - (b) that, “...if a patient walks into my office over the age of 8, they're into the area where it's going to be compromise, it depends how hard they work. If someone comes in at the age of 5, 6 I can almost get a complete correction. If someone comes in younger I can give them advice on how they can correct themselves”.
30. Your claims as set out above at paragraph 29 were inappropriate and/or misleading in that they were made without adequate objective evidence.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of your misconduct.”

The hearing adjourned part heard on 11 October 2024 and will resume on 04 November 2024.