PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

15 to 19 July 2024

Name:	SHAH, Kunal Haresh
Registration number:	201400
Case number:	CAS-204646-L6F5S4

General Dental Council:	Ashraf Khan, Counsel Instructed by Catlin Buckerfield, IHLPS
Registrant:	Present Represented by Ghazan Mahmood, Counsel Instructed by Laura Smith, Clyde & Co

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	12 Months
Immediate order:	Immediate order of conditions

Committee Members:	Peter Watson	(Chair, Lay Member)
	Gezala Umar	(Dentist Member)
	Julie Byrom	(Dental Care Professional Member)
Legal Adviser:	Megan Ashworth	
Committee Secretary:	Lola Bird	

Mr Shah,

1. This is a Professional Conduct Committee hearing in respect of a case brought against you by the General Dental Council (GDC).

2. This hearing is being conducted as a hybrid hearing, with the presenting of the factual evidence, parties' closing submissions and the Committee's deliberations on the facts, having been undertaken in person from 15 to 17 July 2024 at the offices of the Dental Professionals Hearings Service. At the conclusion of parties' closing submissions, it was agreed by the parties that the remainder of the hearing should continue remotely with all parties attending from today, 18 July 2024, by Microsoft Teams video-link.

3. You are represented at these proceedings by Mr Ghazan Mahmood, Counsel. The Case Presenter for the GDC is Mr Ashraf Khan, Counsel.

The charge

4. The charge against you was set out in the formal notice of hearing dated 13 June 2024 as follows:

"That being a registered Dentist:

1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:

a. You did not carry out sufficient diagnostic assessments on:

i. 6 June 2018

ii. 14 June 2018

b. You did not carry out sufficient pretreatment investigations on:

i. 14 June 2018

c. You did not carry out sufficient treatment planning on:

i. 14 June 2018

d. You failed to provide Patient A with all the risks and benefits of the proposed treatment.

e. You failed to refer Patient A to a specialist orthodontist.

f. You provided orthodontic treatment that was not clinically indicated.

g. You provided a poor standard of orthodontic treatment.

2. From 6 June 2018 to 9 December 2020 you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments.

3. By reason of 1a., 1b., 1c., and 1d. from 6 June 2018 to 9 December 2020 you failed to obtain informed consent for the treatment provided to Patient A.

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of your misconduct."

Admissions to the charge – 15 July 2024

5. At the outset of the hearing, Mr Mahmood told the Committee that you admitted heads of charge 1(b), 1(c), 1 (f), 1(g), 2 and 3, in so far as 3 relates to 1(b) and 1(c).

6. The remaining allegations were denied.

Findings in relation to your admissions to the charge – 15 July 2024

7. The Committee heard and accepted the advice of the Legal Adviser, who advised that if the Committee considered your admissions to be clear and unequivocal, it could accept them without requiring the GDC to adduce evidence to prove the allegations in question.

8. Both parties agreed with the Legal Adviser's advice.

9. The Committee confirmed that it was satisfied that your admissions were clear and unequivocal. Therefore, in accordance with paragraph 2.9 of the *GDC's 'Guidance on Admissions made at the Preliminary Stage in Fitness to Practise Proceedings'* (issued in October 2022), the Committee announced the admitted factual allegations at 1(b), 1(c), 1(f), 1(g), 2 and 3, in so far as 3 relates to 1(b) and 1(c), as 'found proved'.

The GDC's opening submissions

10. In opening the case for the GDC, Mr Khan set out the background to the allegations, as outlined in the evidence relied upon by the Council. Mr Khan also provided the Committee with a written copy of his opening submissions.

11. You first registered with the GDC in July 2011, having qualified earlier that same year. The Committee heard that at the material time of the allegations you managed and worked at a dental practice in London ('the Practice').

12. On 2 June 2021, Patient A submitted a complaint against you to the GDC. She stated in her complaint that she had consulted with you in around June/July 2018, as she was suffering from toothache and pain in her jaw. In noting this information, the Committee took into account the dispute between the parties as to the reason Patient A first came to see you. The GDC's opening submissions included placing reliance on the patient's account.

13. Patient A stated that you advised her that her teeth and her jawbone were healthy, and that the issues she was experiencing were due to her crossbite and clenching of her jaw. She said that you advised an NHS mouthguard to prevent her from clenching her teeth at night and causing damage to the teeth. She said that you also advised that a nightguard would not fix the problem entirely, given the issue with her bite. Patient A stated that you told her that the solution was orthodontic treatment, and that she would have to pay for the treatment privately, as the NHS would only cover the cost of orthodontic treatment in severe cases. Patient A stated that she was advised that she would either have to pay for a fixed appliance or for Invisalign treatment.

14. Patient A did not want fixed braces, having worn them as a teenager and not having seen any benefit to wearing a retainer at night. Patient A explained that her wisdom teeth had since come through, causing what she described as overcrowding, with one of her front teeth slightly turned. She stated that overall, she was 'ok' with the appearance of her teeth, but when asked by you she said that she did not like that her two front teeth seemed longer.

15. Patient A maintained that you told her that Invisalign treatment was capable of moving the teeth and correcting her bite, which she said had been the reason behind the initial consultation. She said that you showed her examples of Invisalign treatment on the computer and told her about the benefits of Invisalign. Patient A agreed to return to the Practice to have impressions taken so that she could see what Invisalign treatment could achieve for her dental health.

16. Patient A stated that within a few months of starting the first round of her Invisalign treatment she began to have problems, in that none of her teeth were able to touch. She said that she raised the issue with you, and that you advised that this was normal. She stated that you explained that the final trays *"would bring everything back in".*

17. Patient A stated that the problems continued until *"around aligner 16 – 18"* when, she said, you started to realise that *"something was not right"*. She stated that you then told her that her back teeth had not been included in the original impressions, and that it was those unincorporated back teeth that were preventing the rest of her teeth from closing together. You told Patient A that you would re-do the impressions so that further aligners could be made for a second plan of Invisalign treatment.

18. It was during the second plan that Patient A stated that her bottom teeth appeared not to be moving. Further, Patient A stated that at each appointment you would file between her teeth to create space for them to pass each other. Patient A said that as she progressed with the aligners, her top teeth were fitting well, but her bottom teeth seemed to become more ill-fitting, and *"appeared stuck".*

19. In September 2019, Patient A stated that she told you that she did not think that the Invisalign treatment was working. She said that you told her that the filing of her teeth was safe, and that you advised her to *'go back'* to when the bottom aligners fitted well and re-

wear each of those aligners for a number of days. Patient A stated that this advice was problematic, as by that time she had in excess of 30 worn aligners from two different Invisalign treatment plans. Also, she had not been told that she would need to keep aligners for re-wear.

20. In December 2019, Patient A said that she told you that re-wearing aligners was not working, as she had not kept all of them. She said that you told her that you would speak to a friend, *"who is a specialist"*. You clarified during this hearing that your friend has a special interest in removing wisdom teeth, rather than being a specialist. Patient A further stated that you told her at that stage that her options were: to continue with another round of Invisalign treatment with her wisdom teeth still in, to remove her wisdom teeth before embarking on another round of Invisalign treatment, or to have jaw surgery.

21. In January 2020, further impressions were taken of Patient A for you to use to consult with your friend (with the special interest) who, it was stated, believed that Invisalign treatment would still work for Patient A, and that it may be that her wisdom teeth would need to be removed.

22. It was subsequently confirmed that Patient A's wisdom teeth did need to be removed and she was put on an NHS waiting list for surgery. Patient A stated that by this stage she had been stuck for a period of time with her teeth no being able to touch, and that she was not able to speak or eat properly.

23. Further to your making arrangements, Patient A's wisdom teeth were removed on 8 August 2020 by your friend with the special interest in removing wisdom teeth. An appointment was set up for 9 September 2020 to begin a third plan of Invisalign treatment based on the impressions you had taken of the patient in January 2020.

24. Patient A, still not happy with the service she was receiving from you, sought a second opinion from a specialist orthodontist.

25. Having outlined the details of Patient A's complaint, Mr Khan drew the Committee's attention to the expert evidence obtained by the GDC, in the form of a report prepared by Mr Edward Bateman, dentist, whose expertise is in general dental practice. Mr Khan invited the Committee to have regard to the criticisms made by Mr Bateman in his report in relation to your treatment of Patient A, which form the basis of the matters set out in the charge.

Evidence

26. The Committee received both documentary and oral evidence.

27. The documentary evidence provided by the GDC comprised the witness statement prepared by Patient A for this hearing, dated 31 January 2024. The Committee also received a copy of Patient A's dental records as provided by you to the Council.

28. Also received from the GDC was the witness statement of the specialist orthodontist dated 20 February 2024. The Committee further had before it the expert report of Mr Bateman dated 29 February 2024.

29. The Committee heard oral evidence from Patient A, who attended the proceedings remotely by video-link. Mr Bateman, who attended in person, also gave oral evidence.

30. The written evidence of the specialist orthodontist was agreed by both parties, and the Committee had no questions arising from his witness statement. Accordingly, he was not required to attend to give oral evidence at the hearing.

31. The evidence received on your behalf was your witness statement prepared for this hearing dated 6 June 2024. You also gave oral evidence before the Committee in person.

32. You addressed the factual matters in this case in both your written and oral evidence. In addition to your formal admissions made at the outset of the hearing, you accepted generally that you had made mistakes in your treatment of Patient A.

33. Whilst you maintained your position that you had carried out sufficient diagnostic assessments in relation to the Invisalign treatment you proposed for Patient A, you accepted that some of your findings had been incorrect. In particular, you told the Committee that your findings in relation to the skeletal relationship and the incisor relationship had been incorrect. You recorded both as being *"Class II div II"* when in fact both should have both been '*Class III'*. You accepted that as a result of these erroneous findings, your prescription for Invisalign treatment for Patient A was incorrect. You told the Committee, however, that you had only appreciated your errors after having considered Mr Bateman's expert report.

34. You further accepted that there were deficiencies in your record keeping. You told the Committee that at the material time you were at a relatively early stage in your career as a dentist, and that you did not fully appreciate the importance of documenting every discussion that you had with a patient.

Findings of Fact – 18 July 2024

35. The Committee considered all the evidence presented to it. It took account of the closing submissions made by Mr Khan on behalf of the GDC, and the closing submissions made by Mr Mahmood on your behalf, both orally and in writing. The Committee accepted the advice of the Legal Adviser.

36. The Committee considered separately each of the outstanding factual allegations. It bore in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities. The Committee has had to decide whether it was more likely than not that the alleged facts occurred.

37. For completeness, the following findings made by the Committee include those matters found proved at the outset of the hearing on the basis of your admissions:

1(a)(i)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *a. You did not carry out sufficient diagnostic assessments on:* *i. 6 June 2018* **Found not proved.** In reaching its decision in respect of this allegation, the Committee considered the evidence it received regarding the nature of the appointment on 6 June 2018. The Committee noted that it was not disputed that this was your first appointment with Patient A. However, there was disagreement as to the reason that Patient A consulted with you on this occasion. Patient A stated in her witness statement and was adamant in her oral evidence, that she had first attended to see you because she was suffering with toothache and pain in her jaw. Your evidence, which you said was based on the information recorded in the clinical records, as opposed to your recollection, was that Patient A attended the appointment on 6 June 2018 for a routine examination as a new patient. Your record in the clinical notes for that day is that Patient A attended complaining of *"Nil".* The Committee took into account that your clinical records for Patient A, which are computer-based records, have been considered by the GDC and are accepted as contemporaneous. The Committee was satisfied that there was no evidence before it to suggest otherwise, and Mr Khan was clear that it was no part of the GDC's case that the clinical records had been altered. Therefore, whilst the Committee noted the accepted criticism of your record keeping in that some relevant information had not been documented, it was satisfied that it could otherwise rely on the information in the clinical records. Accordingly, whilst the Committee noted Patient A's recollection, it concluded, based on the information recorded in the contemporaneous clinical records that this first appointment with the patient on 6 June 2018 was for a routine examination as a new patient. Having established this context, the Committee went on to consider whether you carried out sufficient diagnostic assessments in respect of Patient A at this appointment. The Committee had regard to the expert evidence of Mr Bateman, who stated in his report that, *"While the Registrant has recorded a complete*

	dental examination, the same cannot be said of the Orthodontic assessment, which was recorded on 6/06/2018, and on 14/06/2018". The Committee considered the detail of Mr Bateman's criticisms in respect of why he considered your diagnostic assessments were lacking, and it noted that they are all issues pertaining to an orthodontic assessment. It was the view of the Committee, when considering the criticisms, that Mr Bateman had approached Patient A's first appointment on 6 June 2018 as being an orthodontic consultation. However, the clinical records, which have been accepted by the GDC and by the Committee, indicate that the appointment on 6 June 2018 was not an orthodontic consultation, but a routine examination appointment. The Committee noted that it was acknowledged by you in your oral evidence that the clinical charting of 6 June 2018 reflected that Patient A had missing teeth, which may have been due to congenital absence or orthodontic treatment. However, it was not satisfied that it received any compelling evidence to prove on the balance of probabilities that you had a duty to carry out an orthodontic assessment of Patient A on 6 June 2018 in what was a routine examination appointment. Accordingly, the Committee was not satisfied that the GDC discharged its burden of proof in relation to this allegation at 1(a)(i).
1(a)(ii)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *a. You did not carry out sufficient diagnostic assessments on:* *ii. 14 June 2018* **Found not proved.** The Committee noted that both parties referred to this second appointment with Patient A on 14 June 2018 as an orthodontic consultation. The evidence of Mr Bateman, as set out in his report, was that you should have undertaken an orthodontic assessment of Patient A, including on 14 June 2018. The elements that he considered missing from the clinical records in relation to your assessment of the patient were: • Orthodontic history • Extra-oral assessment • Skeletal relationship • Incisor relationship • Overbite • Centrelines.

	Your evidence was that you did carry out sufficient diagnostic assessments of Patient A on 14 June 2018 in line with the elements outlined by Mr Bateman, but that you did not make an adequate record of them. You also accepted that your findings of the skeletal relationship and the incisor relationship were incorrect. You explained in your oral evidence that you followed the algorithm for Invisalign treatment, which was the proposed treatment for the patient. You stated that you had to follow the algorithm, which included the inputting of required information, in order to generate the Invisalign prescription necessary for Patient A's treatment. The Committee noted that Mr Bateman, who confirmed that he was familiar with Invisalign treatment, agreed in his oral evidence that some source information is needed in order to generate an Invisalign prescription for treatment. However, he maintained his view that you had not carried out sufficient diagnostic assessments in respect of Patient A, which included his reservations about whether a sufficient extra-oral examination had been undertaken of the patient based on the written information he had considered. The Committee also took into account that when asked, Patient A could not recall your carrying out a physical examination of her face and neck. Having considered all the evidence, including the evidence about needing to complete an algorithm for the purposes of Invisalign treatment, and the photographic and radiographic evidence provided, the Committee was not satisfied that it is proved to the requisite standard that the diagnostic assessments you undertook were insufficient. The Committee accepted your explanation that you had failed to adequately record all the assessments that you carried out. It also took into account the comment made by Mr Bateman in his report that *"It is possible that the Registrant has carried out all of the above assessments but simply failed to record them in the records".* In finding this allegation at 1(a)(ii) not proved, the Committee took into account your acceptance that your findings in relation to the skeletal and incisor relationships were incorrect, and that this led you to propose Invisalign treatment which was ultimately an inappropriate treatment plan for Patient A. However, the Committee accepted your evidence that your realisation of your mistakes was made in hindsight. It considered that when you proposed the Invisalign treatment you considered it to be an appropriate treatment option based on the assessments you had undertaken. The Committee was not satisfied that it has been presented with sufficient evidence to prove on the balance of probabilities that your diagnostic assessments were insufficient.

1(b)(i)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *b. You did not carry out sufficient pretreatment investigations on:* *i. 14 June 2018* **Admitted and found proved.**
1(c)(i)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *c. You did not carry out sufficient treatment planning on:* *i. 14 June 2018* **Admitted and found proved.**
1(d)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *d. You failed to provide Patient A with all the risks and benefits of the proposed treatment.* **Found not proved.** Patient A exhibited with her witness statement a copy of the *'Invisalign informed consent and agreement'* document which she received from you in respect of her proposed Invisalign treatment. The document is signed by Patient A and is dated 14 June 2018. Under the heading 'Informed consent', it is stated as follows: *" I have been given adequate time to read and have read the preceding information describing orthodontic treatment with Invisalign aligners. I understand the benefits, risks, alternatives and inconveniences associated with the treatment as well as the option of no treatment. I have been sufficiently informed and have had the opportunity to ask questions and discuss concerns with my doctor from whom I intend to receive treatment…"* Patient A was asked during her oral evidence whether she had read the *'Invisalign informed consent and agreement'* document before signing it, and she told the Committee that she had done so. In addition to the *'Invisalign informed consent and agreement'* document, the Committee noted that you recorded in the clinical records having discussed the risks and benefits of Invisalign treatment with Patient A. This is consistent with your written and oral evidence of having had such a discussion. The Committee took into account that the criticism made by Mr Bateman in his oral evidence was around the adequacy of your discussions with Patient

	A about the risks and benefits of the proposed Invisalign treatment. However, that is not the charge. The allegation is that you failed to provide Patient A with all the risks and benefits of the proposed treatment, and in light of the evidence that such information was provided to Patient A, the Committee found 1(d) not proved.
1(e)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *e. You failed to refer Patient A to a specialist orthodontist.* **Found not proved.** The Committee had regard to your clinical records for Patient A across the totality of the period in question. It found that there were numerous occasions when you recorded having advised Patient A that she should be referred to a specialist orthodontist. It also noted that you recorded that Patient A declined your recommendation on each occasion. You told the Committee in your oral evidence that in hindsight, you wished that you had been more assertive in insisting on the referral of Patient A to a specialist orthodontist, given the apparent complexities with her treatment. You said that at that stage in your career, you were relatively inexperienced in terms of your knowledge and expertise, and you said that you had been caught up in the emotion of the situation that you found yourself in with Patient A. However, you also told the Committee that in any event, you had to respect the autonomy of the Patient A's decisions in relation to a specialist referral; you could not make a referral if the patient did not agree to this. The Committee considered it clear from the clinical records that Patient A did not wish to pursue the option of a referral to a specialist orthodontist while under your care. Whilst it noted Mr Bateman's opinion in his report that you failed to refer Patient A for a consultation in respect of further treatment options, the Committee did not receive expert opinion regarding what should or should not be done when a patient refuses to be referred to a specialist. You said and it was submitted on your behalf and not challenged by the GDC, that you had to respect patient autonomy and could not make a referral without a patient's consent. Accordingly, the Committee was not satisfied that it is proved, in light of Patient A's repeated refusal, that you had a duty to refer her to a specialist orthodontist without her consent. In the absence of sufficient evidence indicating such a duty, the Committee could not find that there was a failure on your part. Therefore, this allegation at 1(e) is not proved.
1(f)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:*

	f. You provided orthodontic treatment that was not clinically indicated. **Admitted and found proved.**
1(g)	*1. From 6 June 2018 to 9 December 2020 you failed to provide an adequate standard of care to Patient A, in that:* *g. You provided a poor standard of orthodontic treatment.* **Admitted and found proved.**
2.	*2. From 6 June 2018 to 9 December 2020 you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments.* **Admitted and found proved.**
3.	*3. By reason of 1a., 1b., 1c., and 1d. from 6 June 2018 to 9 December 2020 you failed to obtain informed consent for the treatment provided to Patient A.* **Admitted and found proved in relation to 1(b) and 1(c).** **As the Committee did not find 1(a) and 1(d) proved, this allegation at 3 falls away in relation to those heads of charge.**

38. The hearing now moves to Stage Two.

Stage Two of the hearing

39. The Committee's task at this second stage of the hearing has been to determine whether the facts found proved amount to misconduct, and if so, whether your fitness to practise is impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it would also need to determine what sanction, if any, to impose on your registration.

40. The Committee considered all the evidence presented to it at the fact-finding stage, both oral and documentary. It also considered the additional evidence received at this stage, which was a remediation bundle provided on your behalf comprising of evidence of your postgraduate qualifications, evidence of your Continuing Professional Development (CPD), a number of 'Compliance Documents' and testimonials.

41. The Committee also received your reflective statement dated 17 July 2024 and heard further oral evidence from you.

42. The Committee took account of the submissions made by Mr Khan on behalf of the GDC and those made by Mr Mahmood on your behalf in relation to misconduct, impairment, and sanction.

43. The Committee accepted the advice of the Legal Adviser. It bore in mind that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved

44. The factual findings made by the Committee, all of which you had admitted, relate to the standard of care you provided to one patient, Patient A, from 6 June 2018 to 9 December 2020.

45. Following an initial routine examination appointment with Patient A on 6 June 2018, at an orthodontic consultation on 14 June 2018, you proposed Invisalign treatment, which is a type of orthodontic treatment, to which the patient agreed.

46. Whilst not specifically charged as part of this case, you accepted in your evidence at the fact-finding stage that you made errors at the diagnostic stage of Patient A's treatment. You accepted that your findings in relation to Patient A's skeletal relationship and incisor relationship, which you made at an orthodontic consultation with the patient on 14 June 2018, were incorrect.

47. In relation to further areas of Patient A's treatment, you admitted, and the Committee found proved, that you did not carry out sufficient pre-treatment investigations or treatment planning at the consultation on 14 June 2018.

48. The Committee also found proved on the basis of your admissions that you provided orthodontic treatment to Patient A that was not clinically indicated and that the standard of orthodontic treatment you provided was poor. You further admitted, and it was found proved, that as a result of the failings found proved, you failed to obtain informed consent from Patient A for the treatment you provided to her. Furthermore, you failed to maintain an adequate standard of record keeping in respect of Patient A's appointments over the period in question.

49. You stated in your witness statement dated 6 June 2024 that *"I accept that my assessment of Patient A's skeletal and incisor relationship was incorrect, that I did not carry out sufficient treatment planning and that the treatment ultimately created an open bite. I accept that it was not clinically indicated to proceed with treatment that created such an outcome."* You further admitted that as a result of your failings, you were *"unable to provide Patient A with sufficient information to enable her to make an informed decision as to*

whether to proceed". You expressed the view that, in hindsight, Patient A's case was beyond your expertise at the time and that you should not have provided the Invisalign treatment.

Summary of parties' submissions

50. Mr Khan submitted that there is no definition of misconduct. He stated, however, that guidance on the issue of misconduct is set out in case law, and he referred the Committee to a number of legal authorities. Mr Khan submitted that case law also provides that, when considering the question of misconduct, the Committee should have regard to the professional standards of the regulator.

51. It was Mr Khan's submission that when looking at this case overall, the Committee should make a finding of serious professional misconduct. He highlighted that you advised Patient A that Invisalign treatment was suitable for her, based on your incorrect findings at the diagnostic assessment stage. Mr Khan asked the Committee to note your admission and its finding that Invisalign treatment was not clinically indicated. He submitted that Invisalign treatment would not have helped Patient A with her dental issues. Mr Khan further emphasised your failure to carry out sufficient pre-treatment investigations and treatment planning which, he submitted, resulted in a poor standard of orthodontic treatment which persisted from 2018 to 2020. Mr Khan submitted that over this period, Patient A not only suffered pain as a result of the poor standard of orthodontic treatment, but that she also suffered financial harm, including having herself to seek a specialist orthodontic opinion at additional cost.

52. Mr Khan invited the Committee to have regard to the GDC's *'Standards for the Dental Team'* (effective from September 2013) ('the GDC Standards'). He stated that this publication sets out the standards of conduct, performance, and ethics applicable to all members of the dental team, as well as what the public can expect from dental professionals. It was Mr Khan's submission that the following overriding principles from the GDC Standards are engaged in this case:

Principle 1 – Put patients' interests first.

Principle 2 – Communicate effectively with patients.

Principle 3 – Obtain valid consent.

Principle 4 – Maintain and protect patients' information.

Principle 5 – Have a clear and effective complaints procedure.

Principle 7 – Maintain, develop and work within your professional knowledge and skills.

Principle 9 – Make sure your personal behaviour maintains patients' confidence in you and the dental profession.

53. Mr Khan also referred to a number of the individual GDC Standards that fall under the above principles.

54. In addressing the issue of impairment, Mr Khan submitted that the Committee would need to consider both aspects, namely the public protection aspect of impairment, and the wider public interest aspect. He referred to case law relevant to impairment and outlined the established legal principles to be applied by the Committee in reaching its decision. This included the approach to determining impairment, as set out in the case of *Council for Healthcare Regulatory Excellence v Nursing Midwifery Council and Grant* [2011] EWHC 927 (Admin) (the case of *Grant*), in which the following questions were outlined:

> Do the findings of fact show impairment in the sense that the registrant:
>
> a. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b. *has in the past brought and/or is liable in the future to bring the [dental] profession into disrepute; and/or*
>
> c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [dental] profession; and/or*
>
> d. *…(not relevant).*

55. It was Mr Khan's submission that the factors at a to c above apply in this case. He contended that, going forward, you were liable to act again so as to put patients at unwarranted risk of harm, to bring the dental profession into disrepute, and to breach a fundamental tenet of the profession. He submitted that this is because you have not sufficiently remedied the identified shortcomings in your clinical practice.

56. Mr Khan acknowledged that the facts found proved in this case relate to a single patient and to a discrete aspect of your work as a dentist, namely orthodontic treatment. He submitted, however, that on the evidence provided of your remediation, you do not appear to have addressed the concerns that have been raised about your orthodontic practice. Whilst Mr Khan noted that you no longer carry out orthodontic work, and your stated intention not to do so in the future, he submitted that should you decide to return to that area of practice, patients were liable to be put at risk. He therefore submitted that a finding of impairment is necessary for the protection of the public.

57. Mr Khan further submitted that the matters found proved against you have the potential to undermine public confidence in the dental profession. He submitted that the

identified failings represent a serious departure from proper professional standards, and therefore a finding of impairment is also warranted on public interest grounds.

58. With regard to sanction, Mr Khan referred the Committee to the relevant sections of the *'Guidance for the Practice Committees including Indicative Sanctions Guidance'* (Effective from October 2016; last revised in December 2020) ('the ISG Guidance'). It was Mr Khan's submission that the most appropriate and proportionate sanction would be a conditions of practice order for a period of 18 months. He invited the Committee to consider imposing a set of conditions on your registration that would include requirements for workplace supervision and the production of a log detailing any orthodontic work you have carried out.

59. Mr Mahmood agreed with the approach to be taken in deciding on the issues of misconduct and impairment, as outlined in the GDC's submissions. However, he stated that he disagreed with the GDC's position on what should be the outcome in this case.

60. In relation to misconduct, Mr Mahmood emphasised that case law requires any breach of professional standards to be serious. He submitted that the conduct concerned must be regarded as 'deplorable' by fellow dental practitioners.

61. It was Mr Mahmood's submission that not all of the principles outlined by the GDC from the GDC Standards apply. He contended that only Principles 3, 4 and 7 are relevant on the facts of this case. He invited the Committee to look forensically at the matters admitted and found proved.

62. Mr Mahmood submitted that you did not do anything other than act in the best interests of Patient A taking what you thought was the appropriate approach at the time. He submitted that what can be said is that you were wrong about some of the matters. Mr Mahmood further submitted that there have been no findings in relation to your communication with Patient A, that there has been no evidence to suggest that communication between you broke down or that your communication with the patient was unclear. Mr Mahmood also highlighted the absence of any findings in relation to the issue of complaints. In addition, he strongly opposed any suggestion that Principle 9 is relevant to the matters under consideration.

63. Mr Mahmood submitted that, in reality, this case involves the following three key aspects, and he asked the Committee to bear them in mind when considering the question of misconduct:

1. Your acceptance that you worked beyond your area of expertise at the time when you had insufficient training in Invisalign treatment.

2. Your failure to keep full and proper records in respect of Patient A's appointments.

3. That you failed to obtain informed consent from Patient A for the reason given in your evidence at the fact-finding stage.

64. With regard to impairment, Mr Mahmood acknowledged that the three limbs identified by the GDC from the case of *Grant* were potentially engaged. He submitted that the Committee should consider whether you would be liable to act in future in the ways suggested. Mr Mahmood also invited the Committee to consider paragraphs 4.4 to 4.6 of the ISG Guidance which deal with the issue of impairment.

65. Mr Mahmood asked the Committee to bear four questions in mind when determining current impairment, which were:

1. *How did your errors arise and are they remediable*. It was Mr Mahmood's submission that the errors occurred because of your inexperience at the time, and that they are easily remediable.

2. *Do you have full and proper insight into your failings.* Mr Mahmood submitted that there has been no suggestion by the GDC that your insight into the matters in this case is lacking. He asked the Committee to take into account your full acceptance of your failings and your timely admissions. He stated that you have never sought to deny the impact of your failings, and that you have expressed genuine remorse and taken steps to remedy them, which has included ceasing to provide orthodontic treatment.

3. *Have you remedied all aspects of your previous failings.* Mr Mahmood asked the Committee to have regard to the three aspects outlined at paragraph 63 above in relation to misconduct. He submitted that there was evidence before the Committee in the remediation bundle submitted on your behalf of what you now do differently as a dentist, including that you have specialist referral pathways in place for orthodontic treatment. He also asked the Committee to take into account the testimonial evidence.

4. *Is there a risk of repetition.* Mr Mahmood submitted there is no risk of repetition. He submitted that the Committee's findings relate to events that occurred some years ago, and there has been no evidence of a risk of repetition. He noted the GDC's criticism that you have not learnt more specifically in relation to orthodontics and stated that you have no intention of working in the area of orthodontics again.

66. It was Mr Mahmood's submission in all the circumstances that your fitness to practise is not currently impaired.

67. Mr Mahmood submitted that if the Committee was to make a finding of impairment for public interest reasons, it should consider imposing a reprimand as a sanction.

Decision on misconduct

68. The Committee considered whether the facts found proved in this case amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional. The Committee had regard to its findings and to the GDC Standards, and was satisfied that the following overriding principles are engaged in this case:

Principle 3 – Obtain valid consent.

Principle 4 – Maintain and protect patients' information.

Principle 7 – Maintain, develop and work within your professional knowledge and skills.

69. The Committee considered that Principles 1, 2, 5 and 9 were not engaged in this case, having regard to those allegations that it did not find proved.

70. The Committee found on the basis of your admissions that in respect of the Invisalign treatment you proposed for Patient A, you did not carry out sufficient pre-treatment investigations or sufficient treatment planning. Further, you accepted as part of your evidence that you made errors at the diagnostic assessment stage, which meant that your prescription for Invisalign treatment was incorrect. You have admitted, and it has been found proved, that the orthodontic treatment which you provided was not clinically indicated for Patient A. Further, as a result of your failings you failed to obtain informed consent from her for the treatment that you provided. There were also failures in the standard of your record keeping in respect of Patient A's appointments.

71. Whilst the Committee took into account that its findings relate to your treatment of one patient, and that your failings in pre-treatment investigations and treatment planning, and the errors you made in some of your diagnostic findings, all occurred at one appointment on 14 June 2018, the impact on Patient A was significant. The consequences of your shortcomings were that you failed to provide Patient A with an adequate standard of care over a protracted period of time. The evidence indicates that she suffered harm as a result of your omissions and mistakes in that she was left in a worse position to when she started the treatment with you. After almost two years, Patient A herself sought a specialist orthodontic opinion.

72. The Committee had regard to the expert evidence of Mr Bateman, the expert witness who appeared on behalf of the GDC. His opinion, as given in his report, was that almost all of the failings (now found proved by this Committee) represented conduct that fell far below the standard expected of a reasonably competent general dental practitioner. The only

exception being your failure to carry out sufficient pre-treatment investigations in respect of Patient A. Mr Bateman's opinion was that as an individual failing, taken alone, this was conduct that fell below the expected standard, as opposed to far below.

73. In the Committee's judgment, your overall conduct, as highlighted by the poor standard of treatment you provided to Patient A, represented a serious departure from the requisite GDC principles and standards, and had a considerable impact on the patient. The Committee's view, after considering all the evidence, is that when taken cumulatively the facts found proved in this case amount to misconduct.

Decision on impairment

74. The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

75. The Committee considered that your misconduct, which relates to failings of a clinical nature, is capable of being remedied. In assessing whether your misconduct has been remedied, the Committee had regard to the evidence of the steps you have taken to address the identified shortcomings, as well as the evidence of your insight.

76. The Committee noted that you have undertaken a significant amount of CPD, with reflections on your learning, which has been targeted to a number of the areas of concern. The Committee also had regard to the other evidence provided on your behalf such as the Compliance Documents, which included a report by the Care Quality Commission following an inspection of your practice in November 2019, and the practice's policies and procedures in relation to consent and clinical record keeping. The Committee was further provided with audits of your clinical records undertaken in November 2023 and March 2024.

77. In addition, the Committee had before it your written reflections dated 17 July 2024, in which you openly address the failings in your treatment of Patient A. You state in your reflections that *"I have had a considerable amount of time since the events in question to fully reflect on my shortcomings...I hope the Committee will accept that I am genuinely and truly remorseful for what has happened"*. You outline the additional protocols and procedures that you have put in place to provide reassurance that your practice is in patients' best interests.

78. The Committee was satisfied from the evidence received that you have fully addressed the identified failings in relation to informed consent and record keeping. It also considered from the evidence received at this hearing, including your oral evidence at the fact-finding stage, that you have good insight into what happened in your assessment and

treatment of Patient A and that you have demonstrated genuine remorse for your shortcomings. The Committee noted that you have repeatedly apologised throughout this hearing, including in your written evidence. It was satisfied that you have remedied the identified concerns in relation to informed consent and record keeping such that the risk of repetition of these failings is low.

79. In view of the evidence of your insight, remediation and clear remorse, the Committee carefully considered the likelihood of repetition in respect of the orthodontic concerns. In doing so, it did have regard to your stated intention not to carry out any orthodontic work in future. The Committee also noted the evidence that you have pathways in place for the referral of patients should they need orthodontic treatment. The Committee did not consider that, in and of itself, your decision not to practise orthodontic work sufficiently addressed the deficit in knowledge in this regard.

80. In the Committee's view, the failings identified in relation to Patient A were in basic and fundamental aspects of orthodontic treatment. Further, the Committee took into account that your recognition of some of the mistakes you made in treating Patient A has been relatively recent. You told the Committee that you had not appreciated the errors in your findings in relation to the skeletal and incisor relationships until you considered Mr Bateman's expert report, which is dated 29 February 2024.

81. Therefore, whilst the Committee found you to be a reflective practitioner, who has thought deeply about your misconduct, and who has taken considerable action to address the arising concerns, it concluded that there remains a risk of repetition in this case. In its view, you have not adequately addressed the concern regarding the poor standard of orthodontic treatment you provided to Patient A.

82. The Committee noted from your evidence that you continue to see at least one orthodontic patient for review. Furthermore, it remained mindful, that without any restriction on your registration, orthodontics would be an area of dentistry that you could fully return to in future should your intentions change.

83. It was the conclusion of the Committee, after careful consideration of all the evidence, that without any assurance that you have improved your knowledge and skills in the area of orthodontics, the safety of patients is an ongoing outstanding concern. Accordingly, it determined that a finding of impairment is necessary for the protection of patients.

84. The Committee also determined that a finding of impairment is required in the wider public interest. It considered the harm caused to Patient A from what were basic and fundamental clinical failings. It also took into account that you have not sufficiently remedied the main concerns in relation to your knowledge and skills in orthodontics. The Committee concluded that public confidence in the dental profession would be undermined if a finding of impairment were not made in the circumstances of this case. It also considered that such a finding is necessary to reaffirm proper professional standards.

Decision on sanction

85. The Committee next considered what sanction, if any, to impose on your registration. It noted that the purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and to uphold the wider public interest. In reaching its decision, the Committee had regard to the ISG Guidance. It applied the principle of proportionality, balancing the public interest with your own interests.

86. In deciding on the appropriate sanction, the Committee considered the issue of mitigating and aggravating factors. In mitigation, it took into account the following:

- there is evidence of good conduct following the incident in question, particularly remedial action.
- there is evidence of previous good character in that you have no fitness to practise history.
- there is evidence of remorse shown, insight, and apology given.
- there is evidence of steps taken to avoid a repetition.
- there was no financial gain on your part.
- the fact that the concerns arose in relation to one patient.
- the time elapsed since the incident.

87. The sole aggravating factor identified by the Committee was the harm caused to Patient A.

88. Taking all the above factors into account the Committee considered the available sanctions. It started with the least restrictive, as it is required to do.

89. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration, but in light of the identified risk of repetition in relation to orthodontic practice, the Committee concluded that such an outcome would not serve to protect the public. The Committee also decided that taking no action would undermine public confidence in the dental profession and would fail to uphold proper professional standards.

90. The Committee next considered whether to issue you with a reprimand. However, it had regard to paragraph 6.7 of the ISG Guidance and noted that *"…A reprimand does not impose requirements on a registrant's practice and should therefore only be used in cases where he or she is fit to continue practising without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires*

rehabilitation or restriction of practice". It was the view of the Committee, given the identified ongoing risk to patient safety, that your practice should be restricted and therefore a reprimand would not be sufficient. Further, the Committee considered that a reprimand would not address the wider public interest considerations in this case.

91. The Committee went on to consider whether an order of conditions would be appropriate and proportionate. In reaching its decision, it took into account that this case relates to your treatment of a single patient, albeit with serious shortcomings. You have demonstrated a good level of insight into your clinical failings, and you have taken considerable steps to try and address them. Further, you have demonstrated genuine remorse and issued repeated apologies, including to Patient A.

92. The Committee also took into account that its outstanding concern relates to a discrete area of your clinical practice, namely the risk of repetition should you choose to undertake orthodontic treatment in the future. In all the circumstances, the Committee was satisfied that it could formulate a set of workable conditions. The Committee was also reassured on the evidence before it that you would comply with conditional registration if imposed.

93. In deciding on the sanction of conditions, the Committee considered whether the higher sanction of suspension might be appropriate. It concluded, however, that the suspension of your registration would be disproportionate and punitive, in light of your full engagement with the fitness to practise process, your demonstration of insight, your remorse and apology, and the evidence of remediation already completed.

94. The Committee determined to impose a conditions of practice order on your registration for a period of 12 months. The Committee was satisfied that conditional registration would be sufficient to provide adequate protection to the public and uphold the wider public interest. In deciding on the 12-month period, the Committee had regard to its outstanding concern in this case and it considered that 12 months would be an appropriate and realistic timeframe for you to obtain evidence of your progress under the conditions.

95. For the avoidance of doubt, the workplace supervision requirement included in the conditions applies only to any orthodontic work that you are undertaking or propose to undertake.

96. The Committee imposes the following conditions, which are set out as they will appear against your name in the Dentists Register:

> 1. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services and the Commissioning Body on whose Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland.

2. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any workplace supervisor referred to in these conditions.

3. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.

4. He must inform the GDC if he applies for dental employment outside the UK.

5. He must undertake further training in orthodontics by way of an accredited course(s). This training must be approved in advance by the GDC, and proof of successful completion provided to the GDC.

6. He must not undertake any new orthodontic assessments or commence any new courses of orthodontic treatment, unless and until he has complied with the requirements set out at Condition 5 above.

7. In relation to any orthodontic treatment he provides, including any reviews of ongoing treatment; he must place himself and remain under the supervision* of a workplace supervisor nominated by him, and agreed by the GDC.

8. He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than three months.

9. He must inform within one week the following parties that his registration is subject to the conditions, listed at (1) to (8), above:

- Any organisation or person employing or contracting with him to undertake dental work.
- Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application).
- Any prospective employer (at the time of application).
- The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application).

10. He must permit the GDC to disclose the above conditions, (1) to (9), to any person requesting information about his registration status.

****Supervision:***

The workplace supervisor must supervise the registrant's orthodontic work in a way prescribed in the relevant condition or undertaking. The workplace supervisor does

not need to work at the same practice as the registrant, but they must be available to provide advice or assistance if the registrant needs it. Where the workplace supervisor is unavailable through illness or planned absence, the registrant must not carry out any orthodontic assessment or treatment (including reviews of ongoing treatment), unless an approved alternative workplace supervisor is in place.

The workplace supervisor must review the registrant's orthodontic work at least once a fortnight in one-to-one meetings and case-based discussions. These meetings must focus on all aspects of the registrant's orthodontic practice. These meetings should usually be in person. If this is not possible, at least one of every two fortnightly meetings must be in person.

97. Having imposed the above conditions of practice order, the Committee also directs a review. This means that a future Committee will convene at a resumed hearing to review the order shortly before the expiry of the 12-month period. You will be informed of the date and time of that resumed hearing.

98. Unless you exercise your right of appeal, your registration will be subject to the above conditions, 28 days from the date that notice of this determination is deemed to have been served upon you.

99. The Committee now invites submissions from both parties as to whether an immediate order of conditions should be imposed on your registration, pending the substantive order for conditional registration taking effect.

Decision on an immediate order

100. In considering whether to impose an immediate order of conditions on your registration, the Committee took account of the submissions made by both parties.

101. Mr Khan submitted that an immediate order should be imposed, given that the Committee's finding of impairment is based on both public protection and wider public interest grounds. He referred to the guidance in respect of immediate orders as contained at paragraphs 6.35 to 6.38 of the ISG Guidance. Mr Khan invited the Committee to impose an immediate order on your registration to cover the 28-day appeal period, or in the event that you lodge an appeal, until the resolution of that appeal. It was his submission that immediate action is necessary in this case which relates to poor clinical care.

102. Mr Mahmood opposed the imposition of an immediate order. He submitted that the relevant guidance makes clear that the test for imposing an immediate order is one of necessity rather than desirability. He submitted that the high threshold for imposing such an order has not been met in this case, and he asked the Committee to take into account the evidence of your remediation, insight, and remorse. He also asked the Committee to give

consideration to allowing you the 28-day appeal period to make provisions for your one remaining orthodontic patient.

103. The Legal Adviser confirmed the relevant statutory test for imposing an immediate order, as set out at section 30 of the *Dentists Act 1984 (as amended).*

104. The Legal Adviser also referred the Committee to the case of *Aga v GDC* [2023] EWHC 3208 (Admin). In doing so, the Legal Adviser noted that the GDC is currently in the process of appealing the *Aga* judgement, but she stated that she was obliged to advise the Committee on the law as it currently stands. Therefore, in accordance with the current law, the Legal Adviser advised that if the Committee determined to impose an immediate order on your registration, the effect of *Aga* is that both the immediate order and the substantive order would start at the same time, and that the time served under the immediate order would be offset from the substantive period, which in this case is a period of 12 months.

105. In response to the Legal Adviser's advice, Mr Khan confirmed that the GDC is appealing the *Aga* judgement, and that the Council's position is that the approach to immediate orders that was in place prior to the *Aga* decision is the one that should be followed. However, Mr Khan acknowledged that ultimately it was a matter for the Committee.

106. Mr Mahmood stated that he agreed with the Legal Adviser's advice, and that the mere fact that the GDC was appealing the *Aga* judgment, was not a basis to ignore it.

107. Having heard from both parties, and having heard and considered the Legal Adviser's advice, the Committee determined that the imposition of an immediate order of conditions on your registration (in the same terms set out in the substantive order) is necessary for the protection of the public and is otherwise in the public interest.

108. The Committee has identified an ongoing risk to the public to the extent that it has determined that you require certain restrictions around your orthodontic practice. Whilst the Committee took into account the submissions made on your behalf regarding your one remaining orthodontic patient, it considered that not imposing an immediate order would be inappropriate and inconsistent with its substantive decision. It is the view of the Committee that there would be a risk to the public if you had the opportunity to return to unrestricted practice in the area of orthodontics during the 28-day appeal period, or for potentially longer, in the event of an appeal. An immediate order is therefore necessary to protect the public.

109. The Committee was also satisfied that an immediate order is required in the wider public interest. It considered that immediate action is necessary in this case to maintain public confidence in the dental profession and to uphold proper professional standards.

110. In terms of the running of the immediate order, the Committee accepted the advice of the Legal Adviser regarding the law as it currently stands in light of the judgment in *Aga.*

111. Accordingly, the immediate order and the foregoing substantive order will run concurrently on your registration, with the time spent under the immediate order offset from the substantive period of 12 months.

112. That concludes this determination.