PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

6-10 October 2025

Name:	Haughey, John
Registration number:	104042
Case number:	CAS- 206327 and CAS-209257

General Dental Council:	Ms Louise Price, counsel. Instructed by IHLPS.
Registrant:	Present and unrepresented

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

Committee members:	Martin Isherwood (Chair and DCP member) Gill Jones (Dentist member) Jayne Hidderley (Lay member)
Legal adviser:	Charles Apthorp
Committee Secretary:	Jamie Barge

Heads of charge

"*Whilst being registered as a dentist you:*

Standard of clinical care- diagnostic assessment and pre-treatment investigations

1. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient diagnostic assessments on:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

2. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient pre-treatment investigations on:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Standard of clinical care- radiographic practise

3. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that your radiographic practise was not adequate in relation to:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Standard of clinical care- treatment plan

4. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not undertake sufficient treatment planning on:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Standard of clinical care- treatment options

5. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss all treatment options with:*

    a. *Patient 1*
    b. *Patient 2*

c. *Patient 3*
d. *Patient 4*
e. *Patient 5*

Standard of clinical care- discussion of risks and benefits

6. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss the full risks and benefits of the proposed treatment with:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Informed consent

7. *You failed to obtain informed consent for the treatment provided to:*

    a. *Patient 1 from 30 August 2019 to 03 February 2021*
    b. *Patient 2 from 03 February 2020 to 26 February 2021*
    c. *Patient 3 from 08 July 2020 to 27 July 2021*
    d. *Patient 4 from 07 September 2020 to 16 March 2022*
    e. *Patient 5 from 03 January 2020 to 25 May 2022.*

Standard of clinical care- communicating treatment plan

8. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not adequately communicate a treatment plan to:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Poor standard of treatment

9. *Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you provided a poor standard of aligner treatment or, caused and/or allowed a poor standard of aligner treatment to:*

    a. *Patient 1*
    b. *Patient 2*
    c. *Patient 3*
    d. *Patient 4*
    e. *Patient 5*

Face-to-face contact

10. *You approved treatment to patients without face-to-face patient contact and without ensuring they saw a dentist first, specifically:*

    a. *Patient 1*

b. *Patient 2*
c. *Patient 3*
d. *Patient 4*
e. *Patient 5*

Record keeping

11. *You failed to maintain an adequate standard of record keeping in respect of:*

a. *Patient 1's appointments between 30 August 2019 to 03 February 2021*
b. *Patient 2's appointments between 3 February 2020 to 26 February 2021*
c. *Patient 3's appointments between 8 July 2020 to 27 July 2021*
d. *Patient 4's appointments from 07 September 2020 to 16 March 2022*
e. *Patient 5's appointments from 03 January 2020 to 25 May 2022.*

Complaint handling

12. *You failed to respond adequately to:*

a. *Patient 1's complaint on 16 July 2020 about their dental treatment*
b. *Patient 2's complaint on 11 September 2020 about their dental treatment*
c. *Patient 3's complaint on 30 November 2020 about their dental treatment*
d. *S amended - Patient 4's complaint on 29 November 2021 about their dental treatment.*

13. *You failed to provide an adequate standard of care to Patient 6 from 12 April 2022 to 01 March 2023 by:*

a. *Failing to consider adequately or at all the GDC's guidance on direct-to-consumer/remote orthodontics.*

b. *Not carrying out a full assessment of the patient's presenting dental condition in that:*
   i. *You did not take an adequate dental history;*
   ii. *You did not adequately assess the occlusion of Patient 6's teeth specifically the overbite and overjet, specifically you did not correct the earlier assessment of the teeth as being Class II division 1 malocclusion;*
   iii. *A comprehensive extra-oral assessment;*
   iv. *A comprehensive intra-oral assessment, including noting the rotated teeth and the inclinations of the teeth.*

c. *Not carrying out sufficient pre-treatment investigations in that:*
   i. *You did not conduct an adequate functional assessment of the patient's occlusion;*
   ii. *You did not assess soft tissue harmony both at rest and in function;*
   iii. *Consideration of the extent and impact of Patient 6's TMJD.*

d. *Not carrying out sufficient treatment planning in that:*
   i. *You did not consider and advise Patient 6 of alternative orthodontic systems;*
   ii. *You did not consider, advise or discuss with Patient 6 whether or not it was possible to obtain Patient 6's preferred outcome with Comany 1 system.*

e. *Providing a poor standard of orthodontic treatment, in that:*
    i. *You failed to recognise that the digital images provided to you by Company 1 were not Patient 6's.*

f. *By not discussing the full risks and benefits of the proposed treatment specifically:*
    i. *Its impact upon Patient 6's TMJD;*
    ii. *An increased overbite;*
    iii. *The risks associated with the proclination of the teeth;*
    iv. *The inability of Company 1 aligner treatment to fully correct rotated teeth.*

g. *You failed to obtain informed consent for the treatment provided to Patient 6 from 12 April 2022 to 1 March 2023 in that you did not advise Patient 6 of:*
    i. *alternative treatment options;*
    ii. *patient-specific risks; and*
    iii. *the limitations of treatment.*

h. *You failed to maintain an adequate standard of recording keeping in respect of Patient 6's appointments from 12 April 2022 to 01 March 2023.*

i. *You failed to respond adequately to Patient 6's complaints between 23 December 2022 and 16 August 2023.*

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

FINDINGS OF FACT – 7 October 2025

Haughey [Registration Number: 104042]

1. This is a Professional Conduct Committee hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hybrid hearing in person at the GDC's Wimpole Street office, London, on Monday 6 October 2025, and thereafter remotely via Microsoft Teams in line with current GDC practice. You are present at the hearing and unrepresented. Ms Louise Price, Counsel, appeared on behalf of the General Dental Council (GDC).

GDC application to amend the charge under Rule 18 – 6 October 2025

2. The Committee considered an application, made by Ms Price under Rule 18 of the Rules, to amend one head of charge. She requested minor administrative amendment to heads of charge 12.(d). The following amendment (highlighted) was as follows:

- Allegation 12.(d) – to change date 27 November 2021 to **29** November 2021.

3. The Committee accepted the advice of the Legal Adviser. In granting the application, it had regard to the merits of the case and the fairness of the proceedings, and it was content that the proposed amendment could be made without causing injustice to either party. The Committee was satisfied that the suggested amendment was minor. It accepted that the amendment did not change the substance of the charge against you.

Case background

4. In opening the case for the GDC, Ms Price outlined the background to the matters against you. The complaints in this case relate to 6 patients who approached Company 1 to request clear aligner orthodontic treatment. Company 1 is a direct-to-consumer provider of orthodontic treatments which are conducted entirely remotely using a teledentistry platform. Prospective patients can either attend a 'SmileShop' where detailed photographs and 3D scanned image are recorded by a GDC registered professional or take their own photographs and a mould of their teeth using a kit purchased from the company. Prospective patients complete a medical/dental history form and a consent form.

5. The information is then transmitted via the internet to the USA where the Company 1's 'Set Up Team' create a custom draft treatment plan to address the patient's concerns. This is then sent to a GDC registered dentist or an orthodontist who can approve, revise or reject the plan or request further information. The dentist involved in these cases was you who therefore has responsibility for the cases. You agreed with the GDC expert that you were working in a "*flawed system*".

6. The visual image of the proposed outcome is then transmitted back to the patient and the series of aligners required to achieve the plan are posted to the patient upon receipt of the fees incurred. The dentist/orthodontist with responsibility for the case should review the progress at varying time intervals and if necessary, refinements to the plan should be offered/ made. The GDC expert witness stated that at no time throughout the process does the dentist responsible communicate directly with the patient and the only information the patient knows is the dentist's name.

7. The basis for the complaints from patients 1-5 is that the treatment outcomes were unsatisfactory despite multiple 'refinement' aligners being supplied. It is alleged that you provided inadequate diagnostic assessments, insufficient pre-treatment investigations and radiographic practise. Also, it is alleged that you failed to provide adequate treatment planning and treatment options, as well as a lack of discussion relating to individual cases with regard to risks and benefits. Ms Price stated that nothing specific was said to the individual patients. During the treatment of the

5 patients, it is also alleged that you failed to obtain their informed consent. Ms Price states that there was no record of any discussions about treatment options or how the treatment plan was arrived at.

8. The GDC also alleges that you failed to communicate and discuss the treatment plan with the patients. All 5 patients complained about the standard of aligner treatment and the outcome. The GDC expert witness had concerns about the approval of treatment without face-to-face patient contact. Finally, there are allegations that your record keeping and handling of the patient complaints were poor.

9. There was also a separate complaint received from Patient 6, again relating to the provision of remote orthodontics between 6 April 2022 to 01 March 2023 through Company 1. The treatment provided was an orthodontic treatment, namely an aligner. This was all done remotely. It is alleged that you did not conduct sufficient pre-treatment assessments or planning.

10. It is alleged that you failed to advise Patient 6 on the specific risks and benefits in relation to her, and that you therefore failed to obtain informed consent for the treatment provided to Patient 6 as she was not advised of alternative treatment options; the limitations of treatment and identified risks. Also, there was an alleged failure to maintain an adequate standard of recording keeping in respect of Patient 6's appointments from 12 April 2022 to 01 March 2023. Finally, there is a failure to adequately respond to Patient 6's complaints between 23 December 2022 and 16 August 2023.

Admissions

11. You confirmed that you admitted to the heads of charge in their entirety.

12. Accordingly, the Committee accepted your admissions in relation to the allegations listed above and found those charges proved.

Evidence

13. The factual evidence provided by the GDC includes various documents. The Committee also received the following witness statements, along with associated exhibits:

- A written statement from Patient 2 dated 10 July 2024.
- A written statement from Patient 3 dated 23 July 2024.
- A written statement from Patient 6 dated 17 March 2025

14. The Committee also received expert evidence from Mr Nigel Hunt, on behalf of the GDC. He produced two expert reports dated 4 July 2025 in respect of Patients 1-5, and also a report dated 23 March 2025 in respect of Patient 6. He also provided an addendum report dated 25 March 2025.

15. You gave oral submissions.

16. The Committee heard no oral evidence from any of the witnesses, having accepted all your admissions and found all heads of charge proved.

The Committee's findings on the alleged facts – 7 October 2025

17. The Committee considered all the documentary evidence presented to it. It also took account of the submissions made by Ms Price on behalf of the GDC and those made by you. It accepted the advice of the Legal Adviser.

18. The Committee considered separately each of the allegations against you, bearing 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. This means that the Committee has had to decide whether it is more likely than not that the alleged matters occurred.

19. The Committee's findings are as follows:

	Standard of clinical care- diagnostic assessment and pre-treatment investigations
1.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient diagnostic assessments on:*
1.(a).	*Patient 1* **Admitted and found proved.**
1.(b).	*Patient 2* **Admitted and found proved.**
1.(c).	*Patient 3* **Admitted and found proved.**
1.(d).	*Patient 4* **Admitted and found proved.**
1.(e).	*Patient 5* **Admitted and found proved.**
2.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not carry out sufficient pre-treatment investigations on:*
2.(a)	*Patient 1* **Admitted and found proved.**
2.(b).	*Patient 2* **Admitted and found proved.**
2.(c).	*Patient 3* **Admitted and found proved.**
2.(d).	*Patient 4* **Admitted and found proved.**
2.(e).	*Patient 5* **Admitted and found proved.**
	Standard of clinical care- radiographic practise
3.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that your radiographic practise was not adequate in relation to:*
3.(a).	*Patient 1* **Admitted and found proved.**
3.(b).	*Patient 2* **Admitted and found proved.**
3.(c).	*Patient 3* **Admitted and found proved.**
3.(d).	*Patient 4* **Admitted and found proved.**
3.(e).	*Patient 5* **Admitted and found proved.**

	Standard of clinical care- treatment plan
4.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not undertake sufficient treatment planning on:*
4.(a).	*Patient 1* **Admitted and found proved.**
4.(b).	*Patient 2* **Admitted and found proved.**
4.(c).	*Patient 3* **Admitted and found proved.**
4.(d).	*Patient 4* **Admitted and found proved.**
4.(e).	*Patient 5* **Admitted and found proved.**
	Standard of clinical care- treatment options
5.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss all treatment options with:*
5.(a).	*Patient 1* **Admitted and found proved.**
5.(b).	*Patient 2* **Admitted and found proved.**
5.(c)	*Patient 3* **Admitted and found proved.**
5.(d).	*Patient 4* **Admitted and found proved.**
5.(e).	*Patient 5* **Admitted and found proved.**
	Standard of clinical care- discussion of risks and benefits
6.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not discuss the full risks and benefits of the proposed treatment with:*
6.(a).	*Patient 1* **Admitted and found proved.**
6.(b).	*Patient 2* **Admitted and found proved.**
6.(c).	*Patient 3* **Admitted and found proved.**
6.(d)	*Patient 4* **Admitted and found proved.**

6.(e).	*Patient 5* **Admitted and found proved.**
	Informed consent
7.	*You failed to obtain informed consent for the treatment provided to:*
7.(a).	*Patient 1 from 30 August 2019 to 03 February 2021* **Admitted and found proved.**
7.(b).	*Patient 2 from 03 February 2020 to 26 February 2021* **Admitted and found proved.**
7.(c).	*Patient 3 from 08 July 2020 to 27 July 2021* **Admitted and found proved.**
7.(d).	*Patient 4 from 07 September 2020 to 16 March 2022* **Admitted and found proved.**
7.(e).	*Patient 5 from 03 January 2020 to 25 May 2022.* **Admitted and found proved.**
	Standard of clinical care- communicating treatment plan
8.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you did not adequately communicate a treatment plan to:*
8.(a).	*Patient 1* **Admitted and found proved.**
8.(b).	*Patient 2* **Admitted and found proved.**
8.(c).	*Patient* **Admitted and found proved.**
8.(d).	*Patient 4* **Admitted and found proved.**
8.(e).	*Patient 5* **Admitted and found proved.**
	Poor standard of treatment
9.	*Between 30 August 2019 and 25 May 2022 you did not provide an adequate standard of care in that you provided a poor standard of aligner treatment or, caused and/or allowed a poor standard of aligner treatment to:*
9.(a).	*Patient 1* **Admitted and found proved.**
9.(b).	*Patient 2* **Admitted and found proved.**
9.(c).	*Patient 3* **Admitted and found proved.**
9.(d).	*Patient 4* **Admitted and found proved.**
9.(e).	*Patient 5*

	Admitted and found proved.
	Face-to-face contact
10.	*You approved treatment to patients without face-to-face patient contact and without ensuring they saw a dentist first, specifically:*
10.(a)	*Patient 1* **Admitted and found proved.**
10.(b).	*Patient 2* **Admitted and found proved.**
10.(c).	*Patient 3* **Admitted and found proved.**
10.(d)	*Patient 4* **Admitted and found proved.**
10.(e).	*Patient 5* **Admitted and found proved.**
	Record keeping
11.	*You failed to maintain an adequate standard of record keeping in respect of:*
11.(a).	*Patient 1's appointments between 30 August 2019 to 03 February 2021* **Admitted and found proved.**
11.(b).	*Patient 2's appointments between 3 February 2020 to 26 February 2021* **Admitted and found proved.**
11.(c).	*Patient 3's appointments between 8 July 2020 to 27 July 2021* **Admitted and found proved.**
11.(d)	*Patient 4's appointments from 07 September 2020 to 16 March 2022* **Admitted and found proved.**
11.(e).	*Patient 5's appointments from 03 January 2020 to 25 May 2022* **Admitted and found proved.**
	Complaint handling
12..	*You failed to respond adequately to:*
12.(a).	*Patient 1's complaint on 16 July 2020 about their dental treatment* **Admitted and found proved.**
12.(b).	*Patient 2's complaint on 11 September 2020 about their dental treatment* **Admitted and found proved.**
12.(c).	*Patient 3's complaint on 30 November 2020 about their dental treatment* **Admitted and found proved.**
12.(d).	*As amended - Patient 4's complaint on 29 November 2021 about their dental treatment.* **Admitted and found proved.**

13.	*You failed to provide an adequate standard of care to Patient 6 from 12 April 2022 to 01 March 2023 by:*
13.(a).	*Failing to consider adequately or at all the GDC's guidance on direct-to consumer/remote orthodontics.* **Admitted and found proved.**
13.(b)	*Not carrying out a full assessment of the patient's presenting dental condition in that:*
13.(b).(i)	*You did not take an adequate dental history;* **Admitted and found proved.**
13.(b).(ii).	*You did not adequately assess the occlusion of Patient 6's teeth specifically the overbite and overjet, specifically you did not correct the earlier assessment of the teeth as being Class II division 1 malocclusion;* **Admitted and found proved.**
13.(b).(iii).	*A comprehensive extra-oral assessment;* **Admitted and found proved.**
13.(b).(iv).	*A comprehensive intra-oral assessment, including noting the rotated teeth and the inclinations of the teeth.* **Admitted and found proved.**
13.(c).	*Not carrying out sufficient pre-treatment investigations in that:* **Admitted and found proved.**
13.(c).(i).	*You did not conduct an adequate functional assessment of the patient's occlusion;* **Admitted and found proved.**
13.(c).(ii).	*You did not assess soft tissue harmony both at rest and in function;* **Admitted and found proved.**
13.(c).(iii).	*Consideration of the extent and impact of Patient 6's TMJD.* **Admitted and found proved.**
13.(d).	*Not carrying out sufficient treatment planning in that:*
13.(d).(i).	*You did not consider and advise Patient 6 of alternative orthodontic systems;* **Admitted and found proved.**
13.(d).(ii).	*You did not consider, advise or discuss with Patient 6 whether or not it was possible to obtain Patient 6's preferred outcome with Company 1 system.* **Admitted and found proved.**
13.(e).	*Providing a poor standard of orthodontic treatment, in that:*
13.(e).(i).	*You failed to recognise that the digital images provided to you by Company 1 were not Patient 6's.* **Admitted and found proved.**
13.(f).	*By not discussing the full risks and benefits of the proposed treatment specifically:*
13.(f).(i).	*Its impact upon Patient 6's TMJD;* **Admitted and found proved.**

13.(f).(ii).	*An increased overbite;* **Admitted and found proved.**
13.(f).(iii).	*The risks associated with the proclination of the teeth;* **Admitted and found proved.**
13.(f).(iv).	*The inability of Company 1 aligner treatment to fully correct rotated teeth.* **Admitted and found proved.**
13.(g).	*You failed to obtain informed consent for the treatment provided to Patient 6 from 12 April 2022 to 1 March 2023 in that you did not advise Patient 6 of:*
13.(g).(i)	*alternative treatment options;* **Admitted and found proved.**
13.(g).(ii).	*patient-specific risks; and* **Admitted and found proved.**
13.(g).(iii).	*the limitations of treatment.* **Admitted and found proved.**
13.(h).	*You failed to maintain an adequate standard of recording keeping in respect of Patient 6's appointments from 12 April 2022 to 01 March 2023.* **Admitted and found proved.**
13.(h).(i).	*You failed to respond adequately to Patient 6's complaints between 23 December 2022 and 16 August 2023.* **Admitted and found proved.**

20. We move onto Stage 2.

Stage Two of the hearing

21. 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.

22. 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 95-page remediation bundle provided by you comprising of your written statement and attachments.

23. The Committee also heard oral evidence from you.

24. The Committee took account of the submissions made by Ms Price on behalf of the GDC and those made by you in relation to misconduct, impairment, and sanction.

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

Summary of the facts found proved

26. The factual findings made by the Committee, all of which you had admitted, relate to the standard of care you provided to patients 1-5 in that you provided inadequate diagnostic assessments, insufficient pre-treatment investigations and radiographic practise. Also, you failed to provide adequate treatment planning and treatment options, as well as a lack of discussion relating to individual cases with regard to risks and benefits. During the treatment of the 5 patients, you failed to obtain their informed consent, as there was no record of any discussions about treatment options or how the proposed treatment plan was decided.

27. In addition, the Committee found proved that you failed to communicate and discuss the individual treatment plans with each of the patients. Finally, there were failures in relation to your your record keeping and handling of the patient complaints.

28. Also in respect of Patient 6, between 6 April 2022 to 01 March 2023 through Company 1, the Committee found proved that you did not conduct sufficient pre-treatment assessments or planning. You failed to advise Patient 6 on the specific risks and benefits in relation to Patient 6 and failed to obtain informed consent for the treatment provided to Patient 6. In addition, the Committee found proved a failure to maintain an adequate standard of record keeping in respect of Patient 6's appointments, as well as a failure to adequately respond to Patient 6's complaints between 23 December 2022 and 16 August 2023.

Summary of parties' submissions

29. Ms Price referred the Committee to legal authorities in respect of misconduct. Ms Price 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.

30. It was Ms Price's submission that when looking at this case overall, the Committee should make a finding of serious professional misconduct. Ms Price further emphasised your clinical failures resulted in a poor standard of orthodontic treatment which persisted over a period of time. Ms Price submitted that Mr Hunt's report concluded that a significant number of your failings fell far below the standards expected. She submitted that patients received treatment they didn't need or they did not understand, particularly in respect of Patient 6. In some cases there was a need for remedial work.

31. Ms Price invited the Committee to have regard to the GDC's *'Standards for the Dental Team'* (effective from September 2013) ('the GDC Standards'). She 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 Ms Price's submission that a number GDC Standards are engaged in this case, relating to Principles 1, 2, 3, 4, 5, and 7.

32. Ms Price also referred to a number of the individual GDC Standards that fall under the above principles. She stated that you have accepted that the standard of care you provided to Patients 1-6 remotely. in contrast to the standard of care you would provide in a dental clinic, was below the standards expected. You were aware of what you were doing, yet you did not comply with the GDCs specific guidance on remote orthodontics, which was published in May 2021. You accepted in oral evidence that you were aware of this specific guidance in a GDC newsletter. However at that point, you continued to provide this treatment for over 2 years and only stopped when Company 1 ceased operating.

33. In addressing the issue of impairment, Ms Price submitted that the Committee would need to consider both aspects, namely the public protection aspect of impairment, and the wider public interest aspect. She 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) and also Cohen v GMC 2008 EWHC 581 (Admin).

34. It was Ms Price's submission 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. She submitted that this is because you have not fully accepted the remit of your role and responsibility in providing treatment to these 6 patients. You knew there was specific guidance and that Company's 1 procedures did not follow that guidance, but yet you carried on the treatment for over 2 years. Ms Price submitted that to date you still consider Company 1 responsible for the care provided. You were the responsible treating dentist to all these 6 patients, and under the same duty of care as any other dental professional.

35. Ms Price stated 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 Ms Price noted that you no longer carry out orthodontic work, and your stated intention not to do so in the future, she submitted that should you decide to return to that area of practice, patients were liable to be put at risk. Ms Price submitted that what if another innovative and yet flawed model of care comes along. She further stated could the public be assured there would be no repetition, particularly given that you decided to continue for a 2-year period. She therefore submitted that a finding of impairment is necessary for the protection of the public.

36. Ms Price further submitted that the matters found proved against you have the potential to undermine public confidence in the dental profession. She 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. She submitted that it is required that the profession would have noted that the standard of care you provided is lower than the standards required.

37. With regard to sanction, Ms Price 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 Ms Price's submission that the most appropriate and proportionate sanction would be a conditions of practice order for a period of 12 months. She 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.

38. You gave oral submissions to the Committee. In relation to misconduct, you stated there was no guidance on direct-to-consumer care at that time. You accepted that the standard of care you provided to Patients 1-6 and the handling of their complaints was below the standard expected. However, you stated that this occurred in a remote environment, where you had limited abilities to treat patients orthodontically, and from a standard point of care, you needed to review the 3D treatment plan. You were not able to do this. You accepted you were part of the process and were responsible for the duty of care of all of these patients . You submitted that you did not do anything

other than act in the best interests of the patients taking what you thought was the appropriate approach at the time.

39. With regard to impairment, you stated that your fitness to practise is not currently impaired. You stated that you were working in a flawed system. You tried to change the processes shortly after you became aware on the flaws in the system but you were told by Company 1 "*they will review and get back to you*". You stated Company 1 never got back to you on your concerns. You stated that you had limited training on direct-to-consumer treatment. When Company 1 directly stopped you tried your best to help your patients. All of this experience on this role of direct-to consumer, together with knowledge of relevant GDC guidance, has given you clarity on that type of dentistry, and in terms of risk of repetition, you will not repeat these clinical failures. You stated you will never go back to direct-to-consumer and/or remote dentistry again. You stated to the Committee, that you have accepted your care was not up to standard and will not do this again.

40. It was your submission in all the circumstances that your fitness to practise is not currently impaired.

41. You submitted that if the Committee was to make a finding of impairment, you are willing to comply with conditions, as proposed by the GDC on your registration. However, in respect of the proposed conditions you stated that the terminology of these need to be amended to reflect current GDC guidance.

Decision on misconduct

42. 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 1 – Put patients' interests first.

1.9.1 You must find out about, and follow, laws and regulations affecting your work. This includes, but is not limited to, those relating to:
- data protection
- employment
- human rights and equality
- registration with other regulatory bodies.

Principle 2 – Communicate effectively with patients.

2.1.1 You must treat patients as individuals. You should take their specific communication needs and preferences into account where possible and respect any cultural values and differences.

2.3.1 You should introduce yourself to patients and explain your role so that they know how you will be involved in their care.

2.3.4 You should satisfy yourself that patients have understood the information you have given them, for example by asking questions and summarising the main points of your discussion.

2.3.5 You should make sure that patients have enough information and enough time to ask questions and make a decision.

2.3.10 You should make sure patients have the details they need to allow them to contact you by their preferred method.

Principle 3 – Obtain valid consent.

3.1.1. You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patient's consent.

3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

• options for treatment, the risks and the potential benefits;
• why you think a particular treatment is necessary and appropriate for them;
• the consequences, risks and benefits of the treatment you propose;
• the likely prognosis;
• your recommended option;
• the cost of the proposed treatment;
• what might happen if the proposed treatment is not carried out; and
• whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.

3.1.4 You must check and document that patients have understood the information you have given.

Principle 4 – Maintain and protect patients' information.

4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients. Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

Principle 5 – Have a clear and effective complaints procedure.

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

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.2.1 You must only carry out a task or a type of treatment if you are appropriately trained, competent, confident and indemnified. Training can take many different forms. You must be sure that you have undertaken training which is appropriate for you and equips you with the appropriate knowledge and skills to perform a task safely.

43. The Committee found on the basis of your admissions that in respect of the treatment you provided 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 as well as failing to discuss all treatment options, as well as the risks and benefits. You have also admitted that the orthodontic treatment was below the standards expected of a competent dentist. Further, as a result of your failings you failed to obtain informed consent from the patients for the treatment that you provided. There were also failures in the standard of your record keeping and the handling of the patient complaints.

44. The Committee took into account that its findings relate to your treatment of 6 patients. The consequences of your shortcomings were that you failed to provide these patients with an adequate standard of aligner treatment. The evidence indicates that despite your concerns with the "*flawed system*" you carried on providing this treatment for over 2 years after receiving the GDC guidance on '*direct-to consumer'* treatment. You knew at the material time of the specific GDC guidance yet chose to continue with the orthodontic treatment.

45. The Committee had regard to the expert evidence of Mr Hunt, the expert witness on behalf of the GDC. His opinion, as given in his report, the failings in respect of Patients 1-6 (all found proved by this Committee) represented conduct that fell far below the standard expected of a reasonably competent general dental practitioner.

46. In the Committee's judgment, your overall conduct and behaviour, as highlighted by the poor standard of treatment you provided to the 6 patients, represented a serious departure from the requisite GDC principles and standards, and had an impact on some of the patients. Some of your errors were not isolated and were repeated and had the potential to cause serious harm. The Committee is satisfied that members of the dental profession would find your conduct and behaviour to be deplorable. 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

47. 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.

48. 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.

49. The Committee noted that your written statement and attachments. You outlined the protocols and procedures that you have put in place to provide reassurance that your practice is in patients' best interests and that you will not repeat this type of conduct and behaviour again.

50. However, you did not provide specific evidence of what you will do to ensure there is no risk of repetition. The Committee is not satisfied that you have addressed all the identified failings. It considered from the evidence received at this hearing, including your stage 2 oral evidence that you have demonstrated limited insight into the treatment of these patients. The Committee notes that you have still not accepted full responsibility for the care you provided to all 6 patients. To date you continue to place blame on the system and Company 1. Although you have provided some evidence of remediation and insight, you have not provided an apology or remorse regarding your conduct and behaviour. The Committee is satisfied that you have failed to demonstrate appropriate awareness of your responsibility to the safety and wellbeing of the 6 patients. The Committee noted your concerns of the "flawed system", something which Mr Hunt also acknowledged, however you chose to continue treating these patients after the Company ceased to operate. In your oral evidence, you did not appear to fully appreciate the GDC standards and the impact your serious actions have had on the dental profession. In addition, the Committee noted that despite being aware of the GDC's specific guidance, you continued treating these patients for over 2 years.

51. 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 remote orthodontic work in future. The Committee did not consider that, in and of itself, your decision not to practise remote orthodontic work sufficiently addressed the patient safety component in this regard.

52. The Committee has determined that your fitness to practise is currently impaired. The Committee considers that, whilst your acts and omissions relate to specific, basic and fundamental aspects of dentistry which lend themselves to remediation, you have not demonstrated sufficient insight into and remediation of these matters.

53. The Committee finds that your insight is incomplete, and that you have not properly reflected upon your acts and omissions and their implications for patients and staff and indeed the reputation of the profession. You made full admissions to the facts that the Committee went on to find proved. However, it appears to the Committee that you do not recognise the significance of your actions in relation to public safety and public interest considerations such as the reputation of the profession. The evidence of insight that you have presented to the Committee does not satisfy the Committee that, for instance, you understand the fundamental importance of complying with GDC standards and guidance. Your misconduct is highly damaging to your fitness to practise, and the Committee is not satisfied that your insight and reflections are sufficiently developed for it to conclude that you no longer pose a risk to patients and the public.

54. The Committee finds that the steps that you have taken to remedy your misconduct are similarly lacking. You have presented no evidence of targeted CPD and reflections on aspects of any learning. The Committee notes that there is a lack of evidence that your learning has been embedded in your practice. The Committee considers that you have failed to take ownership of your prolonged failings and you have failed to demonstrate an appropriate level of insight into the facts found proved.. The Committee considers that the process of remedying the deficiencies that the Committee has identified is not complete, and that you continue to pose a risk to patients.

55. In short, the Committee's findings suggest a pattern of behaviour, the lessons of which you do not yet appear to have learnt in full. You continue to pose a risk to the public as a result of failings which have not been addressed to the extent required through reflection and remediation. Accordingly, the Committee finds that your fitness to practise is currently impaired.

56. The Committee also determined that a finding of impairment is required in the wider public interest. It considered 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

57. 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.

58. 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 previous good character in that you have no fitness to practise history.
- the time elapsed since the incident.

59. The aggravating factor identified by the Committee was;

- the harm caused to the patients;
- financial gain on your part;
- breach of trust;
- lack of remorse and apology;
- blatant and wilful disregard to the dental profession; and
- limited insight.

60. 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.

61. 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.

62. 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.

63. 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 6 patients with serious shortcomings. You have demonstrated some insight into your conduct and behaviour, and your actions were not deliberate.

64. 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 the conditions as proposed by the GDC.

65. 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, and that there was no actual patient harm.

66. 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.

67. 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.

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

1. You must provide the GDC, within seven days, the contact details and arrangements for any appointment you accept or are currently undertaking which requires GDC registration, and allow the GDC to exchange information with your employer or any contracting body for which you provide dental services.

2. From the date that these conditions take effect, you must inform the GDC within seven days of being notified of:

i. any formal disciplinary action taken against you;
ii. any NHS investigation;
iii. any regulatory or enforcement action taken against you or a practice for which you are the registered provider;
iv. any patient complaint received about your clinical practice or conduct at work.

3. You must inform the GDC, within seven days of these conditions taking effect, if you are registered with any overseas regulator (or equivalent authority) or within seven days of making an application for registration with any overseas regulator or equivalent authority.

4. You must allow the GDC to exchange information with the Practice, your employer, any organisation for which you have a contract or arrangement to provide dental services and all the NHS regional teams/Health Boards with whom you have an arrangement.

5. You must not be involved with any remote orthodontic services treatment except in accordance with the GDC's statement on 'direct to consumer' orthodontic treatment.

6. At any time you are providing remote orthodontic services;

a)you must agree to the appointment of a workplace supervisor nominated by you and approved by the GDC.
b) The workplace supervisor shall be a GDC registrant,
c) you must not start/restart work until your nominated workplace supervisor has been approved by the GDC.
d) you must permit the GDC and the workplace supervisor to exchange information.

8. You must allow the workplace supervisor to provide reports to the GDC at intervals of not more than 3 months and at least 14 days prior to any review. The following areas should be addressed in the report;

a) Diagnosis assessments;
b) Record keeping;
c) Treatment planning and/or treatment options including discussion of the risks and benefits with patients;
d) Radiography
e) Informed consent.

9. You shall complete a log which must be signed by your workplace supervisor about any remote orthodontic procedures, consultations and advice given to patients with which you are involved.

10. You must provide a copy of the log referred on Condition 10 to the GDC every 3 months.

11. You must inform, within seven days, the following parties within the UK that your registration is subject to the conditions listed at [1] to [10]:

a) Any person or organisation employing you or who has an arrangement with you to undertake dental work;

b) Any professional regulatory body you are registered with, or apply to be registered with (at the time of application);

c) Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application);
• Any prospective employer (at the time of application);

d) The Commissioning body in whose dental Performers List you are included, or seeking inclusion (at the time of application);

e) Your workplace supervisor. You must forward written evidence of your compliance with this condition to the GDC within seven days of notifying the relevant UK parties of your conditions.

12. You must permit the GDC to disclose the above conditions 1 to 11 to any person requesting information about your registration status.

** Supervised the workplace supervisor must supervise the registrant's day-to-day 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 work, unless an approved alternative workplace supervisor is in place.*

The workplace supervisor must review the registrant's work at least once a fortnight in one-to-one meetings and case-based discussions. These meetings must focus on all areas of concern identified by the conditions or undertakings. These meetings should usually be in person, where possible.

69. 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.

70. 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.

71. 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

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

73. The Committee has considered whether to make an immediate order of conditions on your registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

74. Ms Price, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is in the public interest ground following the findings of the Committee that your fitness to practise is currently impaired on both of those grounds.

75. You stated that you are content for the imposition of an immediate order of your registration.

76. The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.

77. The Committee is satisfied that an immediate order of conditions is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of conditions in your case including the risk of repetition, it is necessary to direct that an immediate order of conditions be imposed on both of these grounds. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined.

78. The effect of the foregoing determination and this order is that your registration will be subject to the aforementioned conditions immediately from the date on which notice is deemed to have been served upon you. Unless you exercise your right of appeal, the substantive direction for conditional registration as already announced, will take effect 28 days from the date of deemed service, and continue for a period of 12 months. In the event that you exercise your right of appeal, this immediate order will remain in place until resolution of the appeal.

79. That concludes this hearing.