# Professional Conduct Committee
## Initial Hearing

**29 August – 1 September 2023**
**5 – 6 September 2023**
**1 – 9 October 2024**

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| **Name:** | **GWIZDALA, Michal** |
| **Registration number:** | 290927 |
| **Case reference:** | CAS-202290 |

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| **General Dental Council:** | David Patience, Counsel<br>Instructed by IHLPS |
| **Registrant:** | Present and represented by Giles Colin, Counsel<br>Instructed by Gordon Solicitors |

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| **Fitness to practise:** | Impaired by reason of misconduct |
| **Sanction:** | Reprimand |

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| **Committee members:** | Val Evans | (Chair, lay member) |
| | Sharon Allen | (Dental Care Professional member) |
| | Johanna Bryant | (Dentist member) |
| **Legal adviser:** | William Hoskins | |
| **Committee Secretary:** | Sara Page | |

1. This is a Professional Conduct Committee (PCC) hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams in line with current General Dental Council (GDC) practice.

2. You were present at the hearing and represented by Mr Giles Colin, Counsel, instructed by Gordons Solicitors.

3. Mr David Patience, Counsel, appeared as Case Presenter on behalf of the GDC.

**Finding of facts**

**Background**

4. You are a registered dentist, having first registered with the GDC on 24 August of 2020 following qualifying as a dentist in 2018 at the Medical University of Łódź, Poland. You provided dental treatment to Patient A at an appointment on 21 November of 2020 which took place at The Practice. The Practice had two sets of premises from which it operated, both in London.

5. Patient A was, at the time of the events in question, in her early 20s and had suffered a traumatic fracture of her upper central incisors when she was about 13 years old in December 2011. This was treated in various ways, including a root canal treatment and restorations with composite material. However, Patient A stated that she was advised by various treating dentists over the years that, when she reached a certain age, she would need to get her upper central incisors restored with either crowns or veneers.

6. Patient A attended The Practice to commence treatment on 13 February 2020. The heads of charges you face relate to the dental treatment you provided to Patient A at an appointment on 21 November of 2020. This was the only appointment Patient A had with you.

7. Prior to her appointment with you on 21 November 2020, Patient A attended The Practice on six previous occasions consisting of two consultation appointments and four dental treatment appointments. On 9 July 2020, Patient A had an appointment at which she agreed to have veneers for her four upper front teeth. She was told on this occasion that the treatment would be completed in three further appointments.

8. The first would involve Stage 1 root canal treatment (RCT) and impressions being taken for a home-whitening kit. Patient A would then be required to whiten her teeth at home for three weeks before the second appointment when the teeth would be prepared, and further impressions would be taken for the final veneers following which temporary restorations would be made. Then, the final appointment would be to remove the temporaries and cement the final veneers. Patient A was told that all three of these appointments would be undertaken by the same dentist, Dentist B.

9. On 31 October, Patient A attended The Practice for the final veneers to be cemented. Patient A stated that the veneers for the two upper central front teeth were not a good fit but the two either side were fine. She says Dentist B, nonetheless, cemented three of the veneers that she believed were a good fit and she took a further impression for the fourth one (UL1) so that that veneer could be remade. She also made a further temporary for Patient A for that tooth until that veneer had been remade and she told Patient A she would receive a call from the practice once the new veneer was ready for a further appointment. Patient A stated that she was also told by Dentist B that if any of the veneers needed to be adjusted, this could be dealt

with at the next appointment. She was, again, advised that the root canal would be completed at the next appointment.

10. On 2 November, Patient A telephoned the practice and booked her next appointment for 21 November 2020. She was not told at that point in time that Dentist B had left The Practice and would not be the treating dentist at her next appointment. Patient A stated that on 5 November 2020, she phoned the practice again to advise them that she was not happy with the shape, size and shade of the three veneers that had been cemented on 31 October and wanted them fixed. In response to this, she was told that this would all be dealt with at the next appointment on 21 November 2020.

11. Patient A had her first and only appointment with you on 21 November 2020. On 22 November 2020, Patient A messaged The Practice to complain about what had happened at that appointment, namely her dissatisfaction with the treatment and that her temporary veneers had fallen out the same evening. An appointment was scheduled for her for the next day (23 November 2020) to see the principal dentist at the practice, Dentist A.

12. After this appointment Patient A had multiple appointments with Dentist A who sought to address the concerns that she had had with her teeth. Patient A stated that the experience has caused her a great deal of trauma and distress.

**Evidence**

13. The Committee had regard to a number of documents, including the GDC hearing bundle, and a bundle of documents provided on your behalf. The information provided to the Committee included, but was not limited to, the following documents:

- GDC Expert Witness report of Mr Conor Mulcahy, dated 19 May 2023;
- Defence Expert Witness report of Dr Simon Quelch, dated 21 August 2023;
- Joint Expert Witness report, dated 28 August 2023;
- Your written statement, dated 17 August 2023, and supporting documents;
- Patient A's dental records;
- Written statements and supporting documents of the following witnesses:
  - Patient A;
  - Witness 1 (Dental Nurse at The Practice);
  - Witness 2 (Professional colleague at your current practice);
  - Witness 3 (Owner and principal dentist at your current practice); and
  - Witness 4 (Professional colleague at your current practice).
- Oral evidence was provided by the following GDC witnesses:
  - Patient A;
  - Witness 1; and
  - Mr Mulcahy.
- Oral evidence was provided by the following defence witnesses:

- Witness 2;
- Witness 3;
- Witness 4; and
- Dr Quelch.

- You also gave oral evidence under affirmation.

**Half time application**

**Submission of no case to answer (Wednesday 6 September 2023)**

14. Mr Colin on your behalf, has made a submission under Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules 2006 that there is no case to answer in respect of all of the charges against you, given recent developments in the case.

15. Rule 19(3) of the General Dental Council (GDC) (Fitness to Practise) Rules Order of Council 2006 states:

> *"When the presenter has completed presenting evidence, the respondent or the respondent's representative may open the case for the defence, which may include a submission that there is no case to answer."*

16. Mr Colin referred to Exhibit 9 'unused material disclosure' document. This document set out the following:

> *"Dentist A is subject to multiple FTP investigations which includes allegations relating to failing to maintain an adequate standard of record keeping and allegations that his conduct was misleading and dishonest."*

17. Mr Colin submitted that the allegations made against Dentist A impact the evidence of the GDC expert Mr Mulcahy, Patient A and Witness A. Patient A and Witness A placed significant reliance on Dentist A being the "go-to" dentist and how he managed and treated Patient A as her subsequent treating dentist. He submitted that you have not been afforded the opportunity of cross examination of both witnesses and that is unfair to you.

18. Mr Colin then referred the Committee to Exhibit 11, a telephone attendance note which recorded a conversation on 1 September 2023 between Mr Mulcahy and the GDC. He drew the Committee's attention to the comments made by Mr Mulcahy that he should not have placed reliance on Dentist A's records and that Dentist A's fitness to practise history is relevant. Mr Mulcahy went on to say that that you face serious charges which include dishonesty and that he is not willing to let his evidence be used when it is based on the clinical records of someone facing fitness to practise allegations and that he seeks to withdraw his evidence and wishes that the Committee would disregard it.

19. Mr Colin further referred the Committee to Mr Mulcahy's second addendum report dated 1 September 2023 in which Mr Mulcahy states:

> "*I would like to draw attention to the following:*
>
> - *Dentist A has not provided a statement as to the completeness and accuracy of his dental records.*

- *In giving my opinion I have placed very considerable weight on the assumption that Dentist A's records could be relied upon to be both accurate and complete.*

- *The new information which has been disclosed means that this assumption, in my opinion, can no longer be supported.*

*As a result of the above and mindful of the very serious allegations against the Registrant, I would like to inform the Committee that I now withdraw the evidence I have provided and wish it to be disregarded."*

20. Mr Colin proceeded to take the Committee through the relevant case law, namely *R v Galbraith [1981] 1 WLR 1039* at 1042C and subsequent cases and invited it to consider whether the evidence produced by the GDC is so unsatisfactory, contradictory and/or transparently unreliable that it cannot properly rely on it. He submitted that this case was opened by the GDC on the basis that Mr Mulcahy's evidence was critical of the treatment provided to Patient A by you. Mr Colin submitted that Mr Mulcahy's previous criticism has now evaporated.

21. Mr Colin submitted that the GDC placed heavy reliance on Dentist A's entries in the clinical record and what he communicated to Patient A. It is now evident, he submitted, as to why the GDC did not obtain a witness statement from Dentist A. In his submission, this should not be to your detriment. Mr Colin emphasised that you bore no burden of proof in relation to these allegations and the burden of proof is always on the GDC.

22. Mr Colin submitted that this case essentially hinges on Charge 1.(c). Mr Mulcahy has now withdrawn his evidence to support the contention that you prepared these teeth for crowns and not veneers. Mr Colin referred to the joint expert report and quoted from it in detail as he took the Committee through each of the charges.

23. Mr Colin submitted that even taken at its highest the evidence presented by the GDC is not reliable. The oral evidence that both Patient A and Witness A gave was inherently unreliable, inconsistent within itself and it was inconsistent when placed alongside each other's evidence. He concluded that the evidence on a whole is so unsatisfactory and unreliable that this application should succeed.

24. Mr Patience on behalf of the GDC submitted that it is the Committee who decides whether there is sufficient evidence for a charge to be found proved. He referred to the case of Galbraith and submitted that an evidential test of sufficiency should be applied and this is a lower threshold than the threshold to be applied by the Committee when it comes to find facts. He also submitted that questions of fairness do not form part of the Galbraith test.

25. Mr Patience submitted that Patient A and Witness A gave evidence on which the Committee can safely rely. Patient A was clear in her evidence and made concessions where appropriate. Her evidence is also supported by Witness A who gave clear evidence. Mr Patience submitted that witness evidence will often differ in detail and that any differences in this case do not justify rejecting the entirety of their accounts.

26. Mr Patience went on to address the Committee on each charge.

27. Charges 3.a-b and 4 – Mr Patience reminded the Committee that the stem of Charge 3 includes the word 'failed' which means that there must be a duty. He submitted that expert evidence is not required to prove that there is a duty on a registrant to provide accurate records

as all registrants are required to record what occurs during appointments. Further, the Committee has the evidence of Patient A who categorically denied that the treatment options and risks were explained to her. Mr Patience submitted that if the Committee finds that there is a case to answer in relation to Charge 3, then Charge 4 becomes operative as it is linked to charge 3. He concluded that in relation to charge 3 and 4 in their entirety, there is a case to answer.

28. Charge 1.a-b – Mr Patience submitted that the duty in this charge is self-evident, and an expert is not required to tell the Committee that a Registrant is required to tell a patient in advance about the treatment planned to their teeth and any potential risks. He submitted that Patient A stated that although there was some discussion between you and her, it was mainly her talking at you and that she felt dismissed by you. She stated that you did not tell her at any stage about what you planned to do to her teeth. Further, Witness A in his evidence stated that there was no discussion at the start of the appointment. Mr Patience submitted that there is a case to answer.

29. Charge 1.c – Mr Patience submitted that Patient A and Witness A give mutually supportive evidence that during the appointment you asked Patient A *"you wanted crowns right?"* or words to that effect. He submitted that the Committee can place some weight on Dentist A's clinical records as it may feel that the evidence from Patient A supports those records. Mr Patience did accept that the Committee may feel it needs to approach Dentist A's clinical records with some caution given the recent disclosure. He submitted that there is a case to answer.

30. Charge 2 – Mr Patience submitted that Patient A had stated that she was not told about what was going to happen to her teeth and the potential risks of treatment. It was therefore self-evident that informed consent was not obtained. He submitted that there is a case to answer.

31. Charge 3.c – Mr Patience submitted that if the Committee accept that there is a case to answer in relation to Charge 1.c, it then follows that there is a case to answer in relation to charge 3.c. He submitted that there is a case to answer.

**Committee's decision and reasons on no case to answer application**

32. The Committee has considered the submissions made by both Counsel. The Committee has been referred to the law applicable to a no case to answer application, in particular the principle set out in *R v Galbraith [1981] 1 WLR 1039* at 1042C.

33. The Committee has accepted the Legal Adviser's advice as to the approach it should follow. It has borne in mind that the GDC bears the burden of proving any allegation and that at this stage the Committee is required to determine whether a prima facie case is established so that a properly directed fact finding Committee *could* find the allegation proved.

34. The Committee is not reaching any findings of fact at this stage of proceedings. If it finds that there is a case to answer, this is not an indication that it will inevitably find the charges proved at the end of stage 1. At this stage all the Committee is deciding is whether there is sufficient evidence upon which the Committee *could* find the allegations proved.

35. In its deliberations, the Committee has had regard to the oral and documentary evidence presented by the GDC. The documentary evidence includes a copy of Patient A's signed witness statement, together with her exhibits, along with a witness statement from Witness A. The Committee also received oral evidence from Patient A and Witness A. In addition, it had sight of the clinical records bundle.

36. The Committee considered that it is entitled to have regard to Mr Mulcahy's evidence in relation to your duty to provide an adequate standard of care. It considered that the reason why Mr Mulcahy elected not to stand by his original report and oral evidence is unrelated to, and does not affect, the existence of your duty to provide adequate care. Furthermore, the Committee considered that the existence of such a duty is self-evident.

37. Head of Charge 1(a)(i) - The Committee had regard to Patient A's written and oral evidence some of which is supported by Witness A's evidence. It therefore considers that there is sufficient evidence upon which this charge *could* be found proved. At this stage the Committee does not consider that the evidence offered by Patient A and Witness A is so tenuous that the Committee would be justified in disregarding it. It therefore rejects Mr Colin's application.

38. Head of Charge 1(a)(ii) - For the reasons given above in Head of Charge 1(a)(i). The Committee rejects Mr Colin's application.

39. Head of Charge 1(a)(b) - For the reasons given above in Head of Charge 1(a)(i). The Committee rejects Mr Colin's application.

40. Head of Charge 1(c) - For the reasons given above in Head of Charge 1(a)(i). The Committee rejects Mr Colin's application.

41. Head of Charge 2 - In light of the Committee's conclusions at Charges 1(a)(i) and (ii) it concluded that there is some evidence in relation to the allegation that informed consent was not obtained.

42. Head of Charge 3(a) - The Committee's conclusion in relation to Charge 1(a)(i) is that there is some evidence in relation to an alleged failure by you to discuss and agree the treatment undertaken. It therefore concluded that there is some evidence in relation to an alleged failure by you to maintain an adequate standard of record keeping, having regard to the contents of the clinical record which you made.

43. Head of Charge 3(b) - For the reasons given above in Head of Charge 3(a), the Committee rejects Mr Colin's application.

44. Head of Charge 3(c) - Following the Committee's conclusion that there is some evidence in relation to Charge 1. (c) it concludes that there is some evidence in relation to Charge 3.(c). It therefore rejects Mr Colin's application.

45. Head of Charge 4 is a characterisation of the conduct alleged in Charge 3. In view of the Committee's conclusion in relation to Head of Charge 3, it concluded there is some evidence on which it *could* base any finding of fact in relation to Head of Charge 4. The Committee therefore rejects Mr Colin's application.

**Case resumed on 1 October 2024**

**Rule 18 application to amend the charge**

46. During the course of Dr Quelch's oral evidence, he told the Committee that, in his view, there is a clear distinction between 'valid' consent and 'informed' consent. Following this evidence, the Committee invited Mr Patience to consider whether the GDC considered it to be

appropriate to make an amendment to Charge 2 by substituting the word *"valid"* for the word *"informed".*

47. Having sought instructions from the GDC, Mr Patience made an application to include some additional wording and amend the charge to read as follows:

> *"You failed to obtain **valid and/or** informed consent for the treatment provided to Patient A at an appointment on 21 November 2020."*

48. Mr Patience submitted that whilst the GDC did not consider there to be any distinction between 'valid consent' and 'informed consent', the amendment as proposed would cover any concerns of the Committee in its deliberations relating to Charge 2. He submitted that the case of *Montgomery v Lanarkshire Health Board [2015] UKSC 11,* as referred to in the expert report of Dr Quelch, is the current test for negligence in a civil court and he reminded the Committee that the focus of this hearing is whether or not misconduct has occurred. In the course of its decision-making, Mr Patience submitted that the Committee would need to consider the GDC document, *'Standards for the Dental Team (2013),* ("the Standards") in which the nine principles referred to obtaining *"valid consent".*

49. Whilst Mr Patience confirmed that the GDC did not consider there to be a distinction between the two terms, he made the application in the manner suggested to assist the Committee in its consideration of Charge 2.

50. Mr Colin, on your behalf, submitted that the application was a *"distinction without a difference".* He invited the Committee to be guided by *Montgomery*, as summarised by Dr Quelch in paragraph 5.46 of his expert report and made reference to the Standards. Mr Colin raised no objection to the amendment, as proposed.

51. Having had regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that the amendment could be made without injustice and accepted the amendment as proposed.

**Submissions on Stage 1**

52. On 3 October 2024, Mr Patience, on behalf of the GDC, provided the Committee with written submissions. He submitted that when considering the evidence given by each of the witnesses, the Committee should consider whether the evidence was honest (i.e. were they seeking to tell the truth) and accurate (i.e. were they recalling things correctly and giving accurate and reliable information). Mr Patience invited the Committee to consider assessing whether their evidence is consistent with or supported by other evidence, such as any undisputed or probable facts, any undisputed contemporaneous documentation that is available or the testimony of other witnesses. To assist the Committee in this regard, he referred to the case of *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3650 (Comm).

53. Mr Patience took the Committee through the evidence of Patient A and Witness 1. He also invited the Committee to consider the accuracy and reliability of your evidence.

54. In relation to the expert witnesses' evidence, Mr Patience reminded the Committee that at the close of the GDC's case, Mr Mulcahy had indicated that he wished to withdraw his evidence. However, as was submitted at the time this occurred, it is not within Mr Mulcahy's power to 'expunge' his evidence once it had been given. Therefore, Mr Patience submitted that the

Committee is still entitled to take account of it and accord to it whatever weight it deems appropriate.

55. Mr Patience stated that, following Mr Mulcahy's withdrawal from the case, it may be submitted that Dr Quelch had in effect become the only expert in the case upon whose evidence the Committee should feel confident in being able to place significant weight. However, even if the Committee agreed with that submission, it still remained the case that many of Dr Quelch's views are dependent on what findings the Committee make on the factual evidence. He reminded the Committee that it is not bound by expert evidence and remains, at all times, the judge of the facts.

56. Mr Colin, on your behalf, submitted that it is not hyperbole to state that the GDC's case is *"dead in the water",* as stated by Mr Mulcahy in the telephone attendance note recorded on 1 September 2023 (Exhibit 11). Mr Mulcahy is recorded as having said, *"This is different. Really serious charges, being dishonest. I am not willing to let my evidence be used, when it is based on the notes of someone with this information. So serious, I am not willing to proceed with my evidence."* Mr Colin referred the Committee to Mr Mulcahy's addendum statement, dated 1 September 2023, in which he stated the following:

> *"I would like to draw attention to the following:*
>
> - *Dentist A has not provided a statement as to the completeness and accuracy of his dental records.*
> - *In giving my opinion I have placed very considerable weight on the assumption that Dentist A's records could be relied upon to be both accurate and complete.*
> - *The new information which has been disclosed means that this assumption, in my opinion, can no longer be supported.*
>
> *As a result of the above and mindful of the very serious allegations against the Registrant, I would like to inform the Committee that I now withdraw the evidence I have provided and wish it to be disregarded."*

57. Mr Colin submitted that, given Mr Mulcahy's position, it would be perverse to conclude that Patient A's teeth were prepared for crowns and not veneers. He referred to Dr Quelch's evidence that Patient A's teeth were prepared for veneers, not crowns. He directed the Committee to various paragraphs in his expert report where in his submission Dr Quelch had given a balanced view to justify his final opinion that Patient A's teeth had been prepared for veneers. In the absence of Mr Mulcahy's evidence, Mr Colin submitted that it now appeared, unusually, that the burden of proof has shifted onto you, which cannot be right as a matter of law. He stated that it cannot be said that you have to prove or disprove the matters in some way. Regardless of any decision of the Committee, Mr Colin stated that Mr Mulcahy is not supportive of the GDC's case, and that has to be *"powerful and cogent evidence"* in favour of you and what you have said.

58. Mr Colin then referred the Committee to the clinical record made by you of the appointment with Patient A on 21 November 2020. Mr Colin submitted that it would be perverse to conclude that that entry is a fabrication, or to conclude that it is dishonest, misleading, or lacking in integrity, given the evidence before the Committee. He reminded the Committee that the clinical record was emailed to the practice on 22 November 2020 before there was any detail about the complaint of Patient A. Mr Colin therefore submitted that, if the record was fabricated, this would demonstrate a *"staggering degree of subterfuge"*, and, whilst you were challenged about the veracity of the record, you were not challenged about emailing it on 22

November 2020. There is no evidence that this did not happen. He submitted that this is important and telling in this case because the complaints of Patient A manifest themselves in terms of what she said to Dentist A on 23 November 2020. In this regard, Mr Colin invited the Committee to dismiss all the charges brought against you by the GDC. He urged upon the Committee that the GDC had not discharged its burden of proof and had not satisfied, on the balance of probabilities, that you acted in the manner alleged in each and every charge.

59. In relation to your evidence, Mr Colin submitted that you appeared before the Committee and provided clear and cogent evidence, that you, at no stage, sought to shy away from difficult questions whilst subject to rigorous cross examination. Mr Colin submitted that he would go so far as to submit, in the rather unusual and exceptional circumstances of this case, that you have indeed proved that you did not act in the manner alleged. He stated that you have been entirely truthful in your evidence, measured, and entirely without ulterior motive. Mr Colin informed the Committee that you are a person of good character. Whilst Mr Colin accepted that character evidence does not provide a complete defence it is a factor that can be weighed in the balance. He invited the Committee to take into account that your good character and your unblemished record is such that you can be believed in your affirmation and that you are not the sort of person to behave in the manner alleged by the GDC.

60. Mr Colin informed the Committee that you are a hard-working, dedicated practitioner, and whilst the Committee does not know you personally and has only a snapshot of your work and your demeanour, there is evidence from your colleagues and fellow professionals who speak to your character and their assessment of your practice as a dentist. He stated that those witnesses have all taken time out from their busy work schedules to assist the Committee in its deliberations in providing their opinion on how colleagues, dental professionals and patients regard you.

61. In relation to additional evidence, Mr Colin stated that there has been no evidence provided by Dentist B and any clinical records made by Dentist B are absent, with the GDC's request for these going unanswered. He therefore submitted that the Committee does not have all the evidence required upon which it can properly determine the case against you to a requisite standard. Mr Colin also reminded the Committee that The Practice no longer exists, which he stated was perhaps not a surprise given all the Committee has heard about the chaotic and hectic nature of how the practice was run.

62. Mr Colin told the Committee that Dentist A is subject to multiple fitness to practise investigations that include allegations relating to failing to maintain an adequate standard of record keeping and allegations that his conduct was misleading and dishonest. He submitted that perhaps a reasonable conclusion might be that you are in some way a scapegoat for the shortcomings of The Practice. He told the Committee that you have plainly acknowledged that it is right that you face scrutiny and that you accept that you could have done things better at the appointment on 21 November 2020. Notwithstanding this, Mr Colin submitted that it is clear that Patient A's welfare and wellbeing was at the forefront of your mind throughout the consultation. Further, he submitted that you answered all questions put to you and you were not evasive.

63. With reference to Patient A's account, Mr Colin submitted that the evidence of Patient A cannot be relied upon as it is littered with exaggeration and hyperbole. He stated that the reality of the matter is that it is inherently unlikely that you treated Patient A for crown preparation when that patient, to use her own words, was constantly saying *"veneers, veneers, veneers"* and who was constantly asking what was being done and liked to be involved in every part of the process. Mr Colin submitted that, as at 21 November 2020, Patient A knew what a veneer removal involved, including drilling off current veneers, adjusting the shape underneath and

asking the laboratory to manufacture new ones. He invited the Committee to consider whether there was some collusion between Patient A and Witness 1 who were apparently *"close",* having exchanged telephone numbers. Mr Colin invited the Committee to find that, having assessed Patient A's evidence, it was inherently unlikely that you had prepared her teeth for crowns instead of veneers.

64. In respect of the expert evidence, Mr Colin submitted that the Committee should prefer the evidence of Dr Quelch to that of Mr Mulcahy. He stated that Mr Mulcahy had initially been *"trying too hard"* to advocate for the GDC and to make a case for the GDC and Patient A. Conversely, Mr Colin submitted that Dr Quelch gave a balanced, careful, measured, and reasonable assessment of the evidence provided and was attempting to assist the Committee. He submitted that in giving his opinion, Dr Quelch set out why it is his conclusion that the treatment received by Patient A on 21 November 2020 was veneer preparation. Mr Colin also acknowledged that Dr Quelch was willing to address issues that might suggest crown preparation. As such, Mr Colin submitted that Dr Quelch's evidence was entirely balanced and appropriate.

65. Therefore, Mr Colin invited the Committee to find the facts not proved in their entirety and to dismiss the case against you.

**Committee's findings**

66. The Committee considered all the evidence presented to it and took account of the closing submissions made by Mr Patience on behalf of the GDC and by Mr Colin on your behalf. The Committee heard and accepted the advice of the Legal Adviser, which included reference to relevant case law.

67. The Committee considered each head of charge separately, 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 facts are proved on the balance of probabilities.

Charge 1

*You failed to provide an adequate standard of care to Patient A at an appointment on 21 November 2020 in that:*

*a) You did not, adequately or at all:*

*i. discuss and/or ascertain the nature of Patient A's concerns;*
***NOT PROVED***

*ii. discuss and/or agree with Patient A the treatment that would be undertaken during the appointment.*
***PROVED, in relation to adequacy.***

*b) You did not discuss, adequately or at all, the risks of the treatment that you intended to undertake.*
***PROVED, in relation to adequacy.***

*c) You prepared some or all of the following teeth for crowns, without having informed Patient A beforehand that this was the treatment that would be undertaken during the appointment:*

*i. UL1*
*ii. UR1*
*iii. UR2*
*iv. UL2*

***NOT PROVED, in its entirety.***

68. In respect of Charge 1a)i., the Committee had regard to all the documents provided and the oral evidence of both witnesses of fact called by the GDC and your oral evidence and written statement. The Committee also had regard to the evidence of the experts.

69. The Committee noted that when Patient A attended the practice, she had high expectations and attended expecting to have the deficiencies of the veneers previously fitted by Dentist B addressed at the appointment on 21 November 2020. In her written statement, Patient A stated that Dentist B had informed her that *"…if any of the veneers needed to be adjusted, these could be dealt with at the next appointment."*

70. In her written statement, Patient A stated that she *"was not happy with the shape, size and also the shade of the veneers cemented and that I wanted it fixed."* Patient A stated that she attended the appointment with the expectation that her temporary veneer was going to be removed and the permanent one fixed. She thought the "long one" was going to be filed down and that the "short one" was going to have some material added to it so it would match the others. She also stated that she thought the root canal would be addressed as well.

71. Having had regard to Patient A's clinical records, the Committee noted that you had recorded the following:

> *"c/o dislike the final result disappointed in the shape, colour and the fact that the veneers are too thin. Would like a nice straighter looking smile."*

72. In your witness statement, you recalled *"Primarily from my discussions with Patient A, due to the lack of a treatment plan being available, I believed that she was unhappy with the colour, shape and thickness of the upper 4 veneers which had been placed on the incisors recently".* You told the Committee that you believed your note of the discussion with Patient A adequately addressed the nature of her concerns at the appointment.

73. When Patient A was asked by Mr Patience *"How much time did you spend or did [Dr Gwizdala] spend talking to you about what your concerns were regarding the veneers?",* she replied:

> *"I would say about five, six, seven minutes at most, but then he very, very, very quickly started the treatment, not clearly explaining anything… I feel like what began in the appointment and what ended in the appointment, I feel like there was a massive gap in between where I was not informed this is what the ending of the appointment would be. So I feel like there was definitely a gap in communication there."*

74. Patient A also recalled in her oral evidence that during the discussion that *"…It would have been me mostly doing all the talking, just saying …* "I am not happy with, this one, I am not happy with this", *and then going into detail into what it was that I wasn't happy about."*

75. In light of all the evidence available to it, the Committee concluded that it was clear that a discussion took place between Patient A and you regarding her reason for attending the

practice on 21 November 2020, and therefore it must consider whether or not that discussion was adequate in the circumstances.

76. To assist with its decision making regarding the adequacy of the consultation, the Committee considered the opinions of the expert witnesses. Mr Mulcahy was satisfied in his evidence to the Committee that the clinical records and elements of Patient A's statement support a contention that there was a discussion between you and Patient A. However, Mr Mulcahy opined that, if the Committee was to accept Patient A's assertion that you *"never raised a question*" nor *"asked any details",* such a cursory and one-sided discussion could not be considered adequate.

77. Dr Quelch opined in his oral evidence that you had ascertained some of Patient A's concerns in order to embark upon the treatment that followed. He stated that if Patient A's clinical records are accurate, they detail a discussion that adequately established the nature of Patient A's concerns.

78. Having considered all the evidence before it, and also the clinical record, the Committee preferred the evidence of Dr Quelch and concluded that you did adequately discuss and ascertain the nature of Patient A's concerns before commencing treatment.

79. Accordingly, the Committee found **Charge 1a)i. NOT PROVED.**

80. In respect of Charge 1a)ii., the Committee considered whether you discussed what treatment would be undertaken on 21 November 2020 and whether that discussion was adequate in the circumstances.

81. In your written statement, you recalled, *"Patient A and I had a discussion regarding what was going to be done and I knew her treatment related to the placement of veneers and not the preparation for crowns. It was surprising that she wanted to change her veneers so soon as they had only been placed for a short period of time (i.e. I month) and it is unusual for veneers to be changed so soon."*

82. Patient A's written statements did not make any specific reference to whether discussions took place prior to the treatment being commenced, but she recalled, *"[Dr Gwizdala]… asked me what I was getting done. I mentioned I was expecting to get my veneers checked, the temporary one removed, and potential work carried out on the ones cemented. As I assumed that [Dr Gwizdala] would take off the veneers cemented, my natural teeth buffed, and moulds taken for a new set of veneers to be prepared."*

83. In Patient A's oral evidence, she stated, *"So he told me we could remove them, get new - brand new ones made, but he didn't say he was going to damage my natural teeth underneath them. He didn't say that 80 per cent of my teeth would be removed or 70 per cent or however much high percentage it is that he's removed from my teeth. He didn't say that at all. He didn't then say after me doing this you actually can't have veneers because you're not going to have enough teeth left, he didn't say that…"*

84. In light of Patient A's evidence, the Committee was satisfied that you and Patient A had discussed what treatment would be undertaken during the appointment. It then moved on to decide whether or not that discussion was adequate in the circumstances.

85. Patient A's clinical records indicated that a discussion had taken place and that you had *"Explained to the patient that we can replace the veneers and change the shape, add extra thickness to the material and choose a shade which would satisfy the patients [sic] needs. I*

*explained that this would require drill off current veneers, adjust the shape of the preparation underneath and ask the lab to manufacture new ones."*

86. Whilst it is accepted that this may have been your intended treatment during the consultation with Patient A, the Committee noted the opinion of both experts that until you had removed the veneers, you would be unaware of what is underneath and therefore any initial plans for treatment may be subject to revision. There is no information before the Committee that you informed Patient A of this and that the intended treatment may be subject to change, depending on what further treatment was required following removal of the veneers.

87. You accepted that, once you had removed the veneers, you did not discuss with Patient A whether the treatment options had changed and whether further preparation would be required. In your written statement, you confirmed, *"I admit that I could and should have in hindsight provided Patent A with more detail about the further reduction of tooth material required; however, I deny that I did not adequately discuss with Patient A and obtain her agreement regarding the other aspects of treatment to be carried out."*

88. The Committee accepted that a discussion did take place regarding the treatment that would be undertaken on 21 November 2020 appointment but concluded that discussion was not adequate in the circumstances.

89. Accordingly, the Committee found **Charge 1a)ii. proved, in relation to adequacy**.

90. In respect of Charge 1b), the Committee noted that this was the first occasion on which you had offered treatment to Patient A and that you did not have access to Patient A's full clinical records. In those circumstances, the Committee concluded that you were under a duty to fully discuss the risks of any intended treatment with Patient A. Given that Patient A had very specific aesthetic requirements and high expectations of treatment undertaken, the Committee considered that any discussion of risk needed to be comprehensive.

91. In the clinical notes, you had recorded:

> *"Discussion and tx options:*
>
> *Explained to the patient that we can replace the veneers and change the shape, add extra thickness to the material and choose a shade which would satisfy the patients needs. I explained that this would require drill off current veneers, adjust the shape of the preparation underneath and ask the lab to manufacture new ones. I also offered composite bonding and explained its pros and cons*
>
> *Risks and possible complications of the procedure leading to RCT due to pulp death/ XLA explained to pt, pt confirms that she understands and agrees to proceed (v.c.g)."*

92. In your written statement, you recalled, *"I explained [treatment] would require drill of [sic] the current veneers, adjust the shape of the preparation underneath and ask the lab to manufacture new ones".*

93. In her oral evidence, Patient A stated, *"[You did not discuss this] before [the treatment started] and also…The word* "composite bonding" *never came out of that man's mouth once. Furthermore,* "Risks and possible complications of the procedure leading to root canal [something] due to pulp death", *I was not told that at all."*

94. You also accepted in your written statement that, *"I could have further discussed with Patient A the risks of the treatment undertaken, such as possible sensitivity from the tooth reduction, enamel reduction or possible tooth fracture from the treatment."* In your oral evidence, you accepted that you had not told Patient A that she might have further tooth reduction once you had removed the veneers and were able to assess the position more precisely. Having acknowledged that you did not inform Patient A of the need to remove further tooth tissue, it is inherently unlikely that you would have discussed with her the risks of that procedure.

95. Dr Quelch explained to the Committee that when a tooth is more heavily restored, there is a higher chance of fracture and that, in light of the removal of further tooth material during the treatment, these risks should have been discussed with Patient A. On several occasions, Dr Quelch informed the Committee that the main risk at this particular appointment would have been not being able to meet Patient A's specific aesthetic needs. It was clear that Patient A had high expectations from the appointment, and from the overall course of treatment, but there was no evidence to suggest that it had been discussed with Patient A that it may not have been possible to meet those expectations. Dr Quelch pointed out that there was no recorded discussion of the risk that the treatment intended may not meet Patient A's aesthetic requirements, which he considered to be a significant risk in this case. A discussion of this nature should have been recorded in Patient A's notes.

96. In view of the fact that the notes do not record any discussion of the significant risk referred to by Dr Quelch, your own acknowledgement that you did not discuss some other aspects of Patient A's treatment to the necessary degree, and the Committee's conclusion that you had not discussed the question of further tooth reduction with Patient A, the Committee was satisfied that the discussion was not adequate in the circumstances.

97. Accordingly, the Committee found **Charge 1b) proved, in relation to adequacy.**

98. In respect of Charge 1c), Patient A's written statement recalled, *"Two or three hours into the appointment, I remember mentioning something about veneers, and [Dr Gwizdala's] response was* "Wait you're getting veneers and not crowns?". *I remember asking him to stop, the room went silent, and [Dr Gwizdala] and [Witness 1] looked at each other as if something wrong had happened. I remember starting to cry…"*

99. A further reference to this comment was recorded in Patient A's document 'OFFICIAL STATEMENT – PART 2', in which she wrote, *"It was now 12:30pm… I told [Dr Gwizdala] I wanted the B1 colour as this is the colour, I had on my previous veneer temporaries. [Dr Gwizdala] then said in a rather shocked raised voice* "Wait. You're getting veneers not crowns?" *I said* "Yes I'm getting veneers. I've been talking about veneers during my whole appointment!".*"*

100. Witness 1's written statement recounted a similar scenario, as follows:

> *"[Dr Gwizdala] started with crown prep to some teeth and I was doing the suction. [Dr Gwizdala] gave the patient some anesthetic [sic] before he started treatment. The patient was experiencing some pain and so he gave her more anaesthetic to top it up. I cannot remember any further details, as to what type of anaethetic [sic] or how many times he gave it. She was still feeling pain and asked why he was removing more of her teeth. [Dr Gwizdala] asked,* "You wanted crowns, right?" *and she responded,* "No veneers". *It wasn't only me who was shocked but everyone as this was unusual. The room went quiet. At this point I was holding the suction. The patient panicked and cried…"*

101. In Witness 1's oral evidence, he stated that the "day list" that was available at the practice detailing all the patients and treatments for the day had recorded Patient A as attending for crowns. He stated, *"…there was a day list printed that says that the patient is coming for crowns and this is when [Dr Gwizdala] had a look and he started the treatment."* When asked whether he had seen the "day list", Witness 1 replied, *"I believe so. I think so. I did, yeah. It said crowns. This is something that I am 100 per cent sure about, that it said crowns…"* The Committee noted that Witness 1 did not refer to a "day list" in his written statement or at any time until he provided his oral evidence. This "day list" was never produced in evidence. However, the Committee noted that it had been provided with a screenshot of the appointment list which referred to veneers for Patient A on 21 November 2020.

102. The Committee noted that Patient A was adamant that you had said, in the middle of her appointment, *"You want crowns, right?",* or words to that effect, and that you were preparing her teeth for crowns. The Committee took into account that Witness 1 gave evidence to broadly similar effect, albeit that the words he now recollected were different from those recollected by Patient A. The Committee considered that the variation in the recollections of how your alleged comment was worded impacted on the reliability of the evidence from Patient A and Witness 1. In addition, Witness 1 was unable to provide any information about what he had seen or had not seen about the treatment undertaken on Patient A's teeth at the appointment on 21 November 2020 that would indicate that crowns were being prepared.

103. The Committee concluded that the weight to be given to their recollections against all the other evidence provided was limited, as, on balance there was insufficient evidence from the comments recalled by Patient A and Witness 1 to outweigh all the other facts in the case that suggested that you were always operating to produce veneers, particularly in light of Patient A's assertion that she had been discussing veneers throughout the consultation and the appointment.

104. The Committee also considered the clinical evidence in this regard and referred to the opinions of the expert witnesses.

105. Your clinical notes for the appointment stated:

> *"UR2 UR1 UL1 UL2 ceramic veneers removed using fast speed hp and recent re-moved using slow speed*
> *hp burs, UR1 UL1 core abutments had Class IV MI com- posite build ups*
>
> *Preparations adjusted for ceramic veneers by reducing incisal edges by further 0.5mm to provide more space and adequate coverage palataly. Margins placed equigingivally. Astringent placed into sulci for retraction and to arrest the bleeding.*
>
> *Triple tray and opposite jaw alginate impression taken, bite registration done. Tem-porary veneers fabricated using ProTemp Shade A1 and pre-op alginate and ad-justed in occlusion. Patient mentioned she was dissatisfied with the colour, I reas-sured the pt the are only temps and final veneers will be brighter as per request."*
> *[sic]*

106. In Mr Mulcahy's expert report, he stated that, having assessed the palatal view photographs provided, the evidence supported a contention that the teeth had been prepared for crowns as opposed to veneers based on the tooth preparations appearing to *"extend to the palatal gingival margin of the teeth"*. Mr Mulcahy stated that Dentist A, who saw Patient A on 23 November 2020, considered that the provision of veneers was no longer a viable option and

that it is more likely than not that the teeth were either prepared for crowns in the first instance or so heavily prepared for veneers as to make crowns the more viable option going forward.

107. However, Dr Quelch opined that the photograph provided, even when enlarged, was grainy and there is no evidence of a palatal margin. Dr Quelch informed the Committee that when teeth are prepared for crowns, the bur marks create lines on the surface of the teeth. In his opinion, if the teeth were being prepared for crowns, these bur marks would also be evident on the palatal surfaces in the clinical photograph. Additionally, palatal margins would be visible, but they are not present in the photograph. Also, he indicated that there was some staining visible at UR1 on the temporary restoration which would have been cleaned off the tooth had this tooth been prepared for a crown.

108. The experts also both assessed the photograph provided of the temporary veneers that were removed by you at the appointment on 21 November 2020. In Mr Mulcahy's opinion, he considered that it was clear that at least three of the teeth had been prepared for full coverage restorations (i.e. crowns) as the temporary material shown in the photograph extended significantly down the palatal aspect of the teeth.

109. Dr Quelch stated that the photograph showed that the temporaries had been extended over the palatal surface of the teeth to some extent. However, he stated that if the teeth had had palatal margins, such as in the case of a crown preparation, the material of the temporaries would be thicker and longer palatally. The photograph showed only a very thin extension of the material, which he described as "flash" or excess material. Dr Quelch repeatedly asserted that in his opinion, whilst he was critical of your "over preparation", it had been for veneers and not crowns.

110. Having assessed the photographic evidence and the clinical notes of Patient A, both experts agreed that Patient A's lateral teeth show evidence of veneer preparation, and the central incisors could indicate crown preparation, with, in Dr Quelch's view, the crucial exception of there being no apparent palatal margin.

111. The Committee also had regard to Exhibit 6, which was provided during the course of the hearing, which showed a photograph of the laboratory docket. Of this evidence, Mr Mulcahy stated:

> *"This document lends considerable weight to a contention that the teeth were in fact prepared for veneers. However, there is no record of veneers ever having been returned from the laboratory… It is my opinion that the laboratory docket lends weight to a contention that the teeth were in fact prepared for veneers".*

112. The Committee accepted the evidence of Dr Quelch that the over-preparation of some of the teeth could have been interpreted as crown preparation, but the lack of palatal margins supports that it was more likely that not that you had undertaken veneer preparation. The Committee considered there to be a lack of evidence to support the allegation that there was preparation undertaken for crowns and there was evidence to support the contention that it was veneer preparation undertaken on 21 November 2020.

113. In addition, the Committee acknowledged that the laboratory had been contacted and confirmed that all the invoices submitted, which included one pre-dating the 21 November 2020 appointment, one just after and one in early 2021, were all for veneers, not for crowns. It was accepted that the use of the term "full contour" as referred to on the docket was requested by The Practice and did not indicate that the document was for crowns and not veneers.

114. The Committee determined that, taking all the evidence into consideration including your discussions with Patient A at Charges 1a)I, 1a)ii. and 1b), about the risks of veneers, it would be inherently unlikely that you would then have started preparing the teeth for crowns.

115. Given that both Patient A and Witness 1 said they remembered a comment made about crowns or veneers, it could not be excluded as a possibility, however, that you had begun crown preparation and changed to veneer preparation. However, the Committee has not been presented with sufficient evidence to support you having undertaken crown preparation rather than veneer preparation.

116. The Committee concluded that the GDC has not provided sufficient evidence that the teeth were prepared for crowns, or that treatment was switched from one course of treatment (crowns) to another (veneers) halfway through the appointment. The Committee was satisfied that the evidence provided did support your assertion that you had prepared the teeth for veneers and not for crowns.

117. Therefore, the Committee concluded on the balance of probabilities that you did not prepare Patient A's teeth for crowns and as a result did not have a duty to inform Patient A.

118. Accordingly, the Committee found **Charge 1c) NOT proved, in its entirety.**

Charge 2

*You failed to obtain valid and/or informed consent for the treatment provided to Patient A at an appointment on 21 November 2020.*
***PROVED***

119. In order to ascertain whether there is a requirement to obtain consent, the Committee referred to the Standards, in particular *'Principle 3 – Obtain valid consent'*. The Committee acknowledged the following:

> *Standard 3.1*
> *Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs*
>
> *Standard 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.*
>
> *Standard 3.3*

*You must make sure that the patient's consent remains valid at each stage of investigation or treatment*

*Standard 3.3.1*
*Giving and obtaining consent is a process, not a one-off event. It should be part of on-going communication between patients and all members of the dental team involved in their care. You should keep patients informed about the progress of their care.*

120. The Committee accepted that consent is part of an ongoing process, not just a discussion at the outset of the treatment. The Committee noted that the opinion detailed in the joint expert report was prepared prior to the Committee having heard all the evidence provided during the course of this hearing. Both experts acknowledged that you would not be able to tell exactly what treatment was required for Patient A until you had assessed her mouth, removed the veneers, and assessed the tooth structure. Whilst you recorded in Patient A's clinical notes that verbal consent had been given, Patient A did not sign any documentation at the appointment. There is no documentary evidence that a full and frank discussion took place regarding Patient A's treatment, and you accepted in your oral evidence that you could have had a fuller discussion with Patient A as the appointment progressed.

121. The Committee noted that in the absence of any ongoing discussion with Patient A about her treatment, including any changes to the treatment plan and any further options, you would not be able to obtain valid consent.

122. Therefore, having already found that you did not adequately discuss the treatment that would be undertaken (Charge 1a)i.) and that you did not adequately discuss the risks of treatment (Charge 1a)ii.), you did not obtain valid consent at the 21 November 2020 appointment. The Committee was satisfied that valid consent requires a patient to be provided with relevant options, risks, benefits, and likelihood of success before valid consent can be given. In the absence of these factors, any consent provided is not valid.

123. Accordingly, the Committee found **Charge 2 proved.**

Charge 3

*You failed to maintain an adequate standard of record keeping in respect of an appointment with Patient A on 21 November 2020, in that:*

*a) You recorded that you had explained to Patient A the details of the treatment that would be undertaken during the appointment, when you had not done so.*
***NOT PROVED***

*b) You recorded that you had discussed treatment options and/or risks with Patient A, when you had not done so.*
***NOT PROVED***

*c) You recorded that you had prepared some or all of the following teeth for veneers, when you had in fact prepared them for crowns:*

*i. UL1*
*ii. UR1*
*iii. UR2*

*iv. UL2*
***NOT PROVED in its entirety***

124. In relation to Charge 3a), the Committee had regard to Patient A's clinical records. The Committee has already found in Charge 1a)ii. that you did have a discussion with Patient A regarding the treatment that you were to undertake at the 21 November 2020 appointment, albeit a discussion that was not as extensive as it should have been in the circumstances.

125. The Committee was satisfied that the record you made in Patient A's notes regarding the treatment reflected the discussion that you had. The GDC's case is that you did not have a discussion with Patient A regarding her treatment and that the note you made was a fabrication to cover the fact that you had not had such a discussion.

126. As the Committee found that some discussion took place, albeit an inadequate one, and it therefore could not be said that you recorded treatment options for a discussion that did not take place. Therefore, the Committee concluded that the GDC had not made out its case that you had recorded a discussion when it had not taken place.

127. Accordingly, the Committee found **Charge 3a) NOT proved.**

128. In relation to Charge 3b), the Committee noted that you had recorded the following in Patient A's notes:

> *"Discussion and tx options:*
> *Explained to the patient that we can replace the veneers and change the shape, add extra thickness to the material and choose a shade which would satisfy the patients needs. I explained that this would require drill off current veneers, adjust the shape of the preparation underneath and ask the lab to manufacture new ones. I also offered composite bonding and explained its pros and cons*
>
> *Risks and possible complications of the procedure leading to RCT due to pulp death/ XLA explained to pt, pt confirms that she understands and agrees to proceed (v.c.g)".*

129. The Committee concluded in Charge 1b) that you had a discussion with Patient A regarding her treatment options and some risks albeit that it was not adequate in the circumstances. Therefore, the Committee concluded that the GDC had not made out its case that you had recorded a discussion when it had not taken place.

130. Accordingly, the Committee found **Charge 3b) NOT proved.**

131. In relation to Charge 3c), the Committee noted its earlier finding in relation to Charge 1c) and that there was insufficient evidence to conclude that you prepared the teeth for crowns. As a result of this decision, the Committee found that you recorded that you had prepared Patient A's teeth for veneers as was the case.

132. Accordingly, the Committee found **Charge 3c) NOT proved.**

Charge 4

*Your conduct in relation to charge 3 was:*

*a) Misleading;*

*b) Lacking in integrity;*

*c) Dishonest in that you made entries in the clinical record, recording matters as having occurred in the appointment when you knew that this was not the case.*
***NOT PROVED in its entirety***

133. The Committee found that as a result of its findings at Charge 3, Charge 4 falls away.

134. Accordingly, the Committee found **Charge 4 NOT proved.**

**Decision and reasons on fitness to practise**

135. Having announced its decision on the facts, the Committee then moved on to consider whether the facts found proved amount to misconduct and, if so, whether your practice is currently impaired. Should the Committee find there is current impairment, it can then move on to consider what sanction, if any, to impose.

136. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Mr Patience on behalf of the GDC and from Mr Colin on your behalf in relation to the matters of misconduct, impairment and sanction.

**Evidence**

137. At the start of its considerations in relation to your fitness to practise, the Committee was provided with the following documents:

- Reflective statement, dated 8 October 2024; and
- Your Continuing Professional Development (CPD) bundle.

138. You also provided further oral evidence to the Committee under affirmation.

**Submissions**

139. Mr Patience addressed the Committee on the matters of misconduct, impairment, and sanction.

140. On the matter of misconduct, Mr Patience reminded the Committee that Dr Quelch accepted in cross-examination that your conduct on 21 November 2020 would fall far below the Standards expected if:

i. You had not explained to Patient A, after you had removed the veneers she arrived with, the degree of tooth structure that you planned to remove, which is when you would have been able to properly ascertain this for the first time what treatment you would be undertaking (Charge 1a)ii.);

ii. You had not explained to Patient A the additional risks posed to the teeth, particularly the non-vital teeth, beyond those recorded in the notes as having been provided to her (Charge 1b)); and

iii. Valid/informed consent had not been obtained, given the degree of tooth structure that was being removed from the teeth in question (Charge 2).

141. Mr Patience also invited the Committee to find that your actions had breached a number of the Standards. Furthermore, it is submitted that not obtaining consent for such a significant degree of tooth reduction, having not adequately explained to Patient A the treatment to be undertaken, or the risks involved, would be considered by fellow practitioners to be deplorable. For those reasons, Mr Patience invited the Committee to conclude that the facts found proved do amount to misconduct.

142. On the matter of impairment, Mr Patience invited the Committee to consider the risk to the public and to consider any evidence of remediation. In this regard, he submitted that Silber J observed in *Cohen v General Medical Council* [2008] EWHC 581: *"It must be highly relevant in determining if a doctor's fitness to practice is impaired that first, his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

143. Mr Patience submitted that, in relation to public protection, the GDC does not positively seek to suggest that you present a risk to members the public in your current role. He stated that it is clear that you have demonstrated a degree of insight into the seriousness of the misconduct in this case and you now work in a supportive practice that has better systems in place than those utilised by The Practice. Furthermore, he submitted that some evidence has been put before the Committee of you having undertaken remediative courses in relation to the areas of concern, including obtaining consent, although it was somewhat concerning that you have not undertaken any CPD in the last year. However, he submitted that given the time that has elapsed since the incident, with no apparent repetition, this is not something which should displace the good work you appear to have done previously.

144. However, Mr Patience submitted that the question of risk to the public is not the only consideration and there are public interest factors to be considered as well, as made clear by the observations of Cox J in *Council for Healthcare Regulatory Excellence v (1) NMC & (2) Grant* [2011] EWHC 927, who said as follows at paragraph 74 of that judgment:

> *"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider* ***not only*** *whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

145. In relation to public interest, Mr Patience stated that the facts of this matter are that you 'severely' prepared Patient A's teeth without having obtained consent to do so. He submitted that this was not only clearly contrary to the Standards but was an irreversible procedure, which significantly reduced the restorative options open to Patient A thereafter. Therefore, Mr Patience submitted that a finding of current impairment is required in the public interest, in order to declare and uphold proper professional standards and to maintain public confidence in the profession, by sending a clear message that such significant treatment being undertaken on a patient without their consent, will be taken seriously by the GDC as a regulatory body. This is particularly the case, he submitted, in relation to a highly popular and widespread cosmetic process such as veneer preparation. Furthermore, Mr Patience submitted that an informed member of the public would be surprised and dismayed to learn that no finding of current impairment had been made, in a situation where such a significant degree of tooth

preparation had been undertaken without consent and that this would undermine public confidence in the profession and in the regulatory process.

146. On the matter of sanction, Mr Patience submitted that if the Committee were to find current impairment on public interest grounds only then an order such as conditions, which restricted your ability to practise, might not be proportionate. However, he submitted that if the Committee were to find current impairment on public protection grounds as well, having considered whether there have been sufficient rehabilitative and/or corrective steps undertaken, it might feel that conditional registration would be the appropriate sanction to impose.

147. If the Committee was minded to impose conditional registration, Mr Patience submitted that the imposition of conditions that would require you to work with a Post Graduate Dental Dean, or equivalent, to formulate a Personal Development Plan addressing the issues of consent and communication with patients, would adequately address any outstanding concerns regarding your practice.

148. In relation to a suspension order, Mr Patience submitted that the Committee may feel that such an order is more suitable for cases where there has been repetition of the misconduct or where the misconduct is so serious that the public interest can only be adequately marked by preventing a registrant from being able to practice at all for a period of time. In light of this, and in light of the Committee's earlier findings, Mr Patience stated that the Committee may consider that an order for suspension would not be necessary in the circumstances of this case.

149. Mr Colin, on your behalf, submitted that the matters found proved do not amount to misconduct and there is no current impairment of your current fitness to practise. He reminded the Committee that its findings at Stage 1 focused on the adequacy of your discussions with Patient A and this, he submitted, spoke volumes as to the way the Committee views the conduct that has been found proved.

150. On the matter of current impairment, Mr Colin submitted that it is not sufficient to find that your fitness to practise was impaired at the time when the matters alleged occurred. He stated that the matters in this case are not sufficiently grave and that you are able to demonstrate that you have taken effective actions to remedy the shortcomings in your practice and, more importantly, you can clearly demonstrate to the Committee that you have practised safely since the time of the events in question some four years ago.

151. Mr Colin invited the Committee to bear in mind your first witness statement, in which it is quite clear that, even at the fact-finding stage, you recognised your shortcomings in the consent process. He then invited the Committee to take into account your second, more recent, witness statement, including your reflective statement. Mr Colin submitted that your insight is considerable and that you have reacted appropriately to the concerns this case has raised. He stated that your remorse is obvious and, as set out in writing and in your oral evidence, you have fully remediated any outstanding concerns. He referred the Committee to the *"impressive body of evidence"* you have provided including the diploma you have undertaken, but also the evidence that has been provided by Witness 2, Witness 3 and, most importantly, by Witness 4, the owner and principal dentist of your current workplace.

152. Mr Colin reminded the Committee that you were not long in the United Kingdom at the time you consulted with Patient A. He also submitted that The Practice was a hectic and chaotic organisation where you had little introduction and little support, and invited the Committee to see the events of 21 November 2020 as a series of very unfortunate circumstances that

collided in a dramatic and regrettable way. Mr Colin submitted that this was a single isolated incident in an otherwise unblemished career and the Committee can be reassured that you have responded appropriately; there has been no repetition of similar conduct, and you have worked without incident in four years. He also reminded the Committee that you are currently working in a very supportive practice. Therefore, he submitted that your fitness to practise is not currently impaired.

153. If the Committee were to find impairment, Mr Colin submitted that such a finding alone would be sufficient in all the circumstances in this case and that no further action would be required, as patient safety and public interest would be adequately addressed. He stated that the Committee might also consider a reprimand, as this is the only other sanction that would be proportionate in the circumstances.

154. Having heard the submission of both Mr Patience and Mr Colin, the Committee heard and accepted the advice of the Legal Adviser.

**Misconduct**

155. The Committee acknowledged that misconduct was defined, in the case of *Roylance (No. 2) v General Medical Council [2000] AC 311* as, "…*a word of general effect, involving some act or omission, which falls short of what would be proper in the circumstances with the standard of propriety often being found by reference to the rules and standards ordinarily required to be followed by a [registrant] in the particular circumstances*."

156. In considering whether any or all of the facts found proved amount to misconduct, the Committee had regard to the following principles from the Standards, in particular:

> *Standard 2.1*
> *You must communicate effectively with patients – listen to them, give them time to consider information and take their individual views and communication needs into account*
>
> *Standard 2.2*
> *You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care*
>
> *Standard 2.2.1*
> *You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:*
>
> - *explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and*
> - *give full information on the treatment you propose and the possible costs.*
>
> *Standard 3.1*
> *Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs*
>
> *Standard 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.*

*Standard 3.3*
*You must make sure that the patient's consent remains valid at each stage of investigation or treatment*

*Standard 3.3.1*
*Giving and obtaining consent is a process, not a one-off event. It should be part of on-going communication between patients and all members of the dental team involved in their care. You should keep patients informed about the progress of their care.*

157. The Committee took into account that a breach, or breaches, of the relevant Standards does not automatically result in a finding of misconduct.

158. The Committee noted its earlier findings that you had failed to obtain valid consent from Patient A regarding the removal of further tooth material on 21 November 2020 and that this amounted to an inadequate standard of care. Given Patient A's high expectations and her continued engagement with her treatment, the Committee was satisfied that without keeping Patient A fully informed of the treatment options throughout her appointment, and thereby failing to obtain valid consent, your conduct reflected a standard far below that expected.

159. Therefore, the Committee determined that your conduct was a sufficiently serious departure from the Standards as a dental professional to amount to misconduct.

**Impairment**

160. In its consideration of impairment, the Committee bore in mind the advice of the Legal Adviser who reminded the Committee that it must find current impairment of fitness to practise. It took into account that it is not sufficient to find that your fitness to practise was impaired at the time that the matters found proved took place, but that it must be found that your fitness to practise is impaired as of today.

161. The Committee first considered whether your conduct was likely to be repeated in the future and was assisted by the 'test' outlined in *Cohen v GMC,* namely whether your misconduct is remediable; whether it had been remedied; and whether there is a risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare proper standards of conduct and behaviour to maintain public confidence in the profession and this regulatory process.

162. The Committee took into account that the clinical failings in this case are capable of remediation, and it therefore considered what actions you have taken since the concerns came to light to remedy your previous failings. It took into account that you have undertaken a number of CPD courses and completed a Postgraduate Diploma in Restorative and Aesthetic

Dentistry. The Committee was satisfied this was demonstrative of the practical steps you have taken to avoid repetition of similar conduct in the future.

163. The Committee recognised that the misconduct in this case is limited to one appointment with one patient some four years ago which involved a particularly difficult working environment shortly after you had begun practising as a dentist in the UK. In your oral evidence, you explained to the Committee that, in the four years since the incident, you have come to understand the expected standards for dental practitioners in the UK and the disappointment in yourself for not having provided the best treatment to Patient A.

164. The Committee was reassured by the evidence both from you and your colleagues, including the owner and principal dentist of your current practice who made very clear statements about how valued you are by your patients and how valued you are as a colleague. Witness 4 told the Committee that he had no reservations at all regarding your practice and considered you to be an extremely good dentist. Witness 4 provided the Committee with a lot of information, both in his written and oral evidence, that, from the moment you joined the practice, you were very open about the GDC investigation. Witness 4 also said that you had chosen to actively engage in learning from him and other colleagues. Witness 4 stated that you have developed as a practitioner and is very happy for you to treat his patients, commenting that some of his patients, having been treated by you, have chosen to remain with you as their treating dentist.

165. The Committee noted that the practice that you have been working at since April 2021 is a very different environment from the one at The Practice and it was clear from the evidence provided that you are highly regarded, not only by your colleagues, but by your patients. In this regard, the Committee acknowledged the many complimentary and positive reviews and statements of your patients that were provided on your behalf.

166. It was clear from your evidence throughout the course of these proceedings that you have learned a salutary lesson from this process and have sought to carefully address your previous failings. It was accepted by the Committee that you made poor decisions during Patient A's appointment but that you have been able to demonstrate that you have made significant progress since November 2020 to mitigate against the risk of similar conduct in the future.

167. The Committee concluded that you have remediated your misconduct and that you have demonstrated significant insight and genuine remorse. The Committee is of the view that, having considered all the information before it, there is an extremely low risk of repetition. Therefore, a finding of impairment is not necessary on the ground of public protection.

168. In its consideration of the wider public interest, the Committee referred to the case of *CHRE v NMC and Grant* and whether public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

169. The Committee bore in mind that the misconduct in this case was an isolated incident involving one patient at one appointment some four years ago, in which the consent you obtained was not sufficient in the particular circumstances of that appointment.

170. The Committee referred to the ISG and noted that it stated:

> *"The issue of informed or valid consent is a cornerstone of the public interest and must be paramount in a registrant's mind prior to carrying out any treatment or investigation. Failure to obtain consent is a serious matter and, if the panel is*

*satisfied that it amounts to misconduct the PCC should consider whether a finding of impairment and the imposition of a sanction is appropriate in the public interest."*

171. The Committee concluded that, given the fundamental importance of obtaining valid consent, particularly where significant treatment is being undertaken on a patient, an informed member of the public would be surprised to learn that a finding of impairment was not made in this case.

172. Therefore, the Committee concluded that a finding of impairment is required on the ground of public interest.

**Decision and reasons on sanction**

173. In coming to its decision on sanction, the Committee considered what action, if any, to take in relation to your registration. It took into account the GDC's document *'Guidance for the Practice Committees, including Indicative Sanctions Guidance 2016 (Revised December 2020)'*, 'the ISG'. The Committee reminded itself that any sanction imposed must be proportionate and appropriate and, although not intended to be punitive, may have that effect.

174. Having carefully considered paragraph 5.17 of the ISG, the Committee considered the following mitigating factors to be present in this case:

- *evidence of the circumstances leading up to the incident in question;*
- *evidence of good conduct following the incident in question, particularly any remedial action;*
- *evidence of previous good character;*
- *evidence of remorse shown/insight/apology given;*
- *evidence of steps taken to avoid a repetition;*
- *the fact that the incident was a single, isolated event; and*
- *time elapsed since the incident.*

175. In its consideration of paragraph 5.18 of the ISG, the Committee considered the following aggravating features to be present in this case:

- *actual harm or risk of harm to a patient (not obtaining valid consent).*

176. The Committee had regard to its previous findings on misconduct and impairment in coming to its decision and considered each sanction in ascending order of severity.

177. The Committee first considered whether to take no further action but concluded in having found impairment on public interest grounds, it would not adequately address its findings in that regard and that your misconduct ought to be marked to ensure a clear message was sent to the public about the importance of dental practitioners obtaining valid consent before undertaking treatment.

178. In its consideration of whether to issue a reprimand, the Committee considered that, although serious, the misconduct in this case is at the lower end of the spectrum, due to its isolated nature. The Committee was satisfied that you do not pose a risk to patients or the public and therefore you do not require rehabilitation or restriction of practice.

179. The Committee was satisfied that the following factors outlined in the ISG are present in this case:

- *there is no evidence to suggest that the dental professional poses any danger to the public;*
- *the dental professional has shown insight into his/her failings;*
- *the behaviour was an isolated incident;*
- *the behaviour was not deliberate;*
- *the dental professional has genuinely expressed remorse;*
- *there is evidence that the dental professional has taken rehabilitative/corrective steps; and*
- *the dental professional has no previous history.*

180. Having given the matter careful consideration, the Committee determined that a reprimand is the appropriate and proportionate sanction to impose in the particular circumstances of this case. It found that you are a practitioner of good character with no previous fitness to practise concerns and do not pose a risk to the public. It accepted that you have demonstrated clear remorse and insight into your failings that would mitigate against any future risk of repetition.

181. The Committee did consider the imposition of conditional registration but concluded that there are no concerns regarding your clinical practice going forward and to restrict your practice for any period of time would be disproportionate.

182. Therefore, in all the circumstances, the Committee considered that the issuing of a reprimand was sufficient to mark the seriousness of the misconduct found in this case. It was satisfied that a reprimand adequately addressed the public interest considerations and would maintain trust and confidence in the profession whilst declaring and upholding proper professional standards. The Committee was confident that a reasonable informed observer would note the Committee's findings of facts, misconduct and impairment, and would consider that the sanction of a reprimand represents a suitable and proportionate response.

183. In issuing a reprimand, this sanction is publicly recorded as the outcome of the case against you and a copy of the determination will appear alongside your name on the GDC register for a period of 12 months. The Committee was satisfied that this is sufficient to mark your misconduct as a serious departure from the standards expected of a registered dental professional and must not happen again.

184. The reprimand will form part of your fitness to practise history and is disclosable to prospective employers and prospective registrars in other jurisdictions.

185. This will be confirmed to you in writing in accordance with the Act.

186. That concludes this hearing.